2006

STIHealth KY

Start of Year Procedures

STI

This guide was created jointly by STI and the Kentucky Department of Education.

Information in this document is subject to change without notice. Student and school data used herein are fictitious unless otherwise noted.

Software Technology, Inc.
4721 Morrison Drive, Suite 200
Mobile, AL 36609-3350
1-877-844-0884

This document was last modified on June 22, 2006. Any subsequent changes made to the STI applications described herein will be discussed in the release notes that accompany each product's update.

Contents

Start of Year Procedures 1

Move Alert Messages 1
STIHealth 9.0 DATA STANDARDS - 2006-07 2
Purpose 2
2006-07 End of Year Reporting 2
Immunizations 4
Physical Exam Information 6
Vision Exam Information 7
Vision Screening Information 8
Hearing Screening Information 9
Scoliosis Screening Information 10
Allergy/Alert 11
Allergy Data Entry 12
Changes and Updates 13
Allergy/Alert 13
Medication 14
Medication and Reason 14
STIOffice View Window 16
Student Health Profile 16
Reports 16
District Health Changes and Updates 17
Student Desktop 17
Allergies/Alerts 18
Medication 19
Student Profile 20
Report Desktop 20
Multiple Data Path Setup 22
Add/Edit Student Information Desktop 23
Batch Entry 24
Medical 26
Accident Report 26
Daily Log 27
Immunization 28
Medication 31
Referrals 33
Screenings 33
Reports Desktop in STIHealth 34
Selecting Students for Reports 37
Generating Reports 37
Generating Letters 38

Appendix A 40

Release Notes for STIHealth Update (Version 9.0) 40

Appendix B **44**

Release Notes for STIDistrict Health Update (Version 9.0.0) 44

Appendix C **46**

Immunization Shot Compliance Report Guide 46
Step I: Keys to Interpreting Codes for each designated shot type: 46
Step II: Interpreting the Shot Type 46

Appendix D **50**

KDE Contacts 50

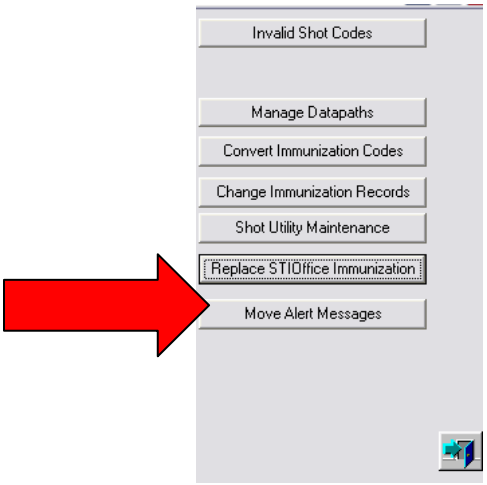
Index **53**

Start of Year Procedures

Move Alert Messages

This MUST be done after updating to Version 9.0!!!
This will move Alert Message, Allergy and Unusual Health Condition records from the "Medical" button to the "Allergy/Alerts" button, and add new codes to the appropriate code banks. The alert messages will be moved to the Health Conditions Description textbox with "Other" in the drop down box to the left. The alert checkbox will be auto-selected when the alert message(s) are moved to the screen. It will be necessary to go in and clean up the data, by selecting the appropriate allergy or health condition from the drop down menus.

To run the Utility the user needs to go to Utilities | Utility Window | Move Alert Messages.
(This utility only needs to be run once at each school.)



STIHealth 9.0 DATA STANDARDS - 2006-07

Modified June 19, 2006

Division Data Policy Management and Research
Kentucky Department of Education
500 Mero Street, 15th floor
Frankfort, KY 40601
(502) 564-5279

Purpose

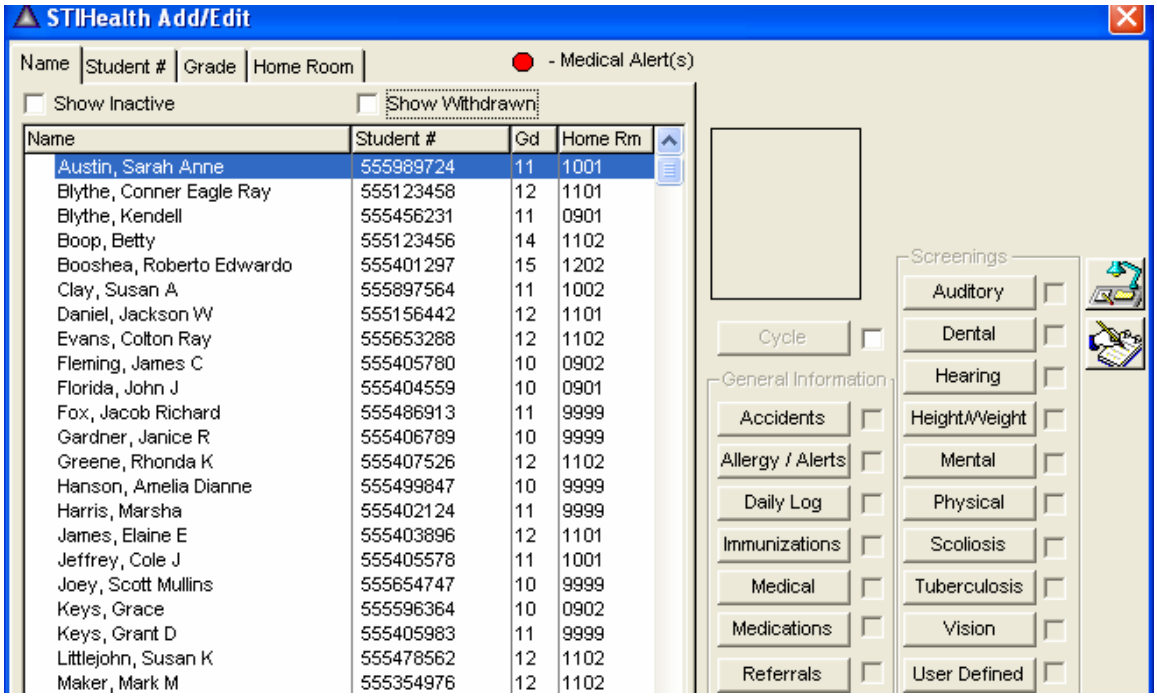
The purpose of the STIHealth data standards document is to give Kentucky public schools a guideline in which to follow when entering student health information in the STIHealth product. The data elements outlined in this document are the fields that are required to be entered for KDE reporting purposes. Each page documents the grade level in which the information is required according to state and federal laws.

2006-07 End of Year Reporting

(From STI District Health)

- ✓ Student Health Report
- ✓ Health Conditions Report
- ✓ Alert Messages Report

Student Add/Edit Screen

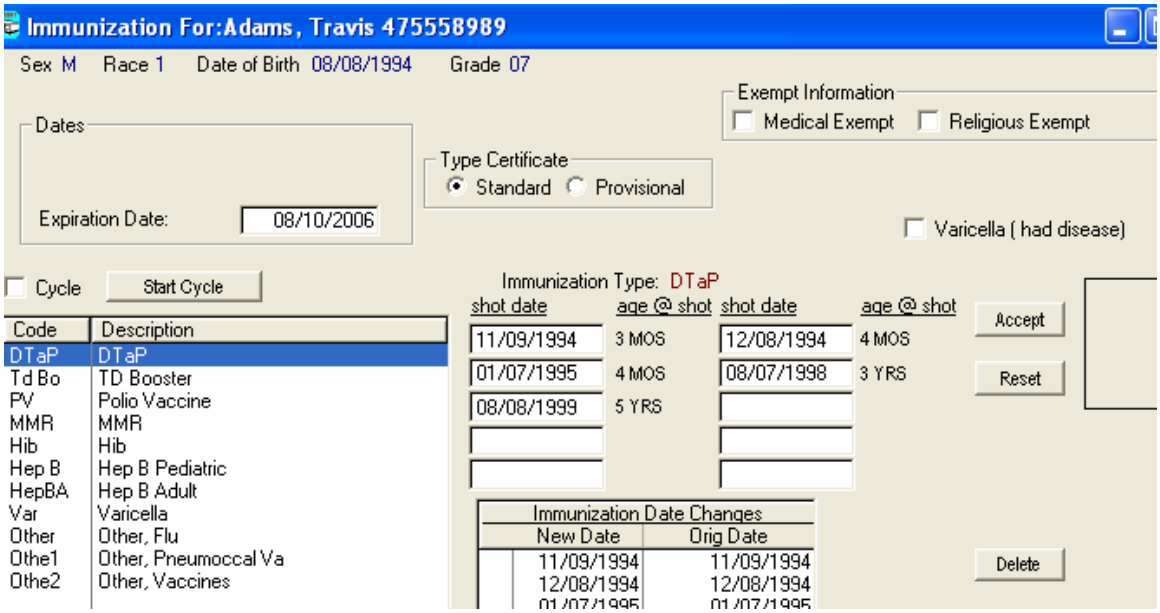


Cycle Feature: Will allow the user to go immediately from one student to the next after entering the selected data for each student.

Batch Entry: Choose this option to enter screening data for multiple students (batch of students) at one time.

Immunizations

(Initial Entry and 6th Grade Only)



Certificate Expiration Date: Enter the expiration date of the certificate submitted. If religious exemption is checked, no expiration date is required.

Type Certificate: Choose appropriate check box (Standard, Provisional)

Exempt Information: Choose the appropriate check box if child is exempt from immunizations (Medical, Religious). Options to add notes to medical exempt field.

Medical Exempt Notes: If Medical Exempt selected, a notes field is activated, enter immunization exempt information in this field, i.e. MMR

Options for entering immunizations dates:
Cycle Feature: This will allow the user to cycle through the shots on immunization certificate
Shot updates: Highlight the specific shot you're updating

***Reminder:** Must click the accept button after entering date fields for individual shot types in order for the dates to be saved. Dates will appear in immunization date box as pending. Pending means that it is not a permanent record yet, dates can be altered at this point. Information becomes permanent after clicking OK to exit the screen.

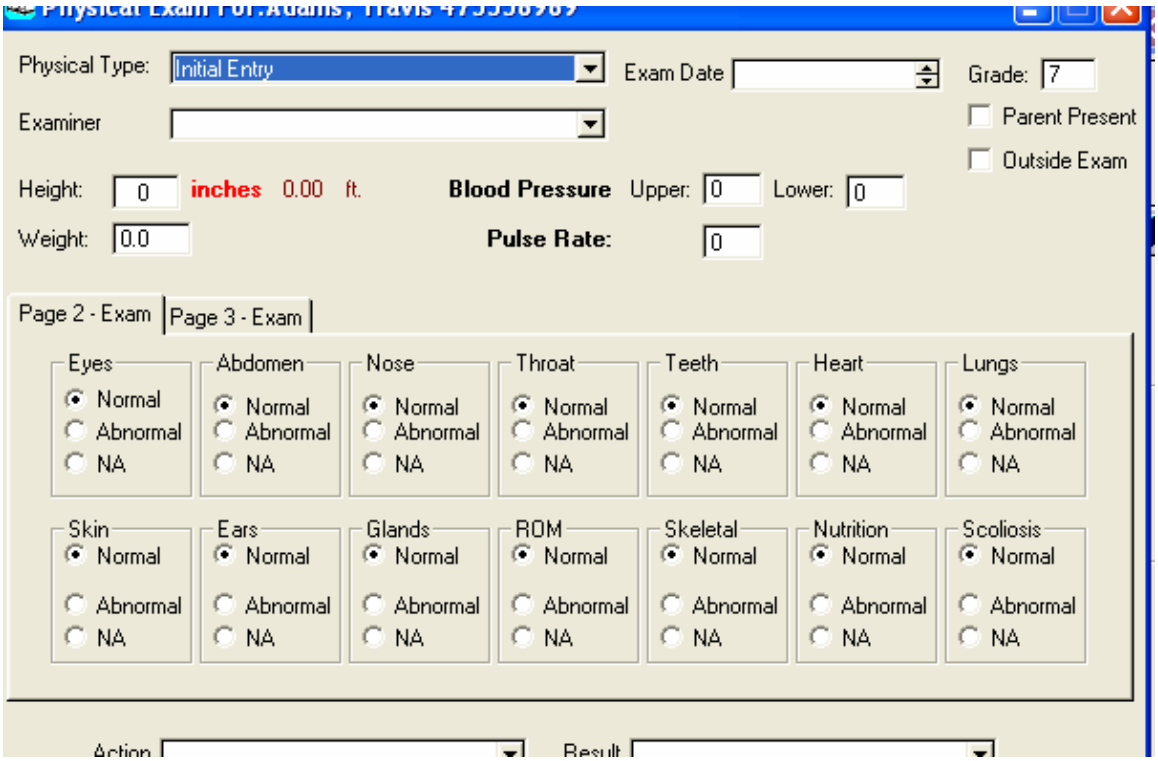
Enter dates of the following vaccinations from the student's immunization certificate:

STI Health 8.0	Equivalent Immunization Certificate Abbreviations
DTaP	**Diptheria, Tetanus, Pertussis (DT, DTaP, or DTP)**
Td Bo	**Td Booster, Tdap, Adult Td Vaccine or Boostrix**
PV	**Polio Vaccine (OPV or IPV)**
Hib	**Hib (Haemophilus influenza type b)**
MMR	**Measles, Mumps, Rubella or measles containing vaccine**
HepB	**Hepatitis B (pediatric dose; 3 shot series)**
HepBA	**Hepatitis B (adult dose; 2 shot series)**
Var	**Varicella (chicken pox vaccine)**

Preschool Hib rules will be forwarded as a fix from STI late in the year.

Physical Exam Information

(Initial Entry and 6th Grade Only)



Physical Type: Select from drop down menu 'Initial Entry or '6th Grade'

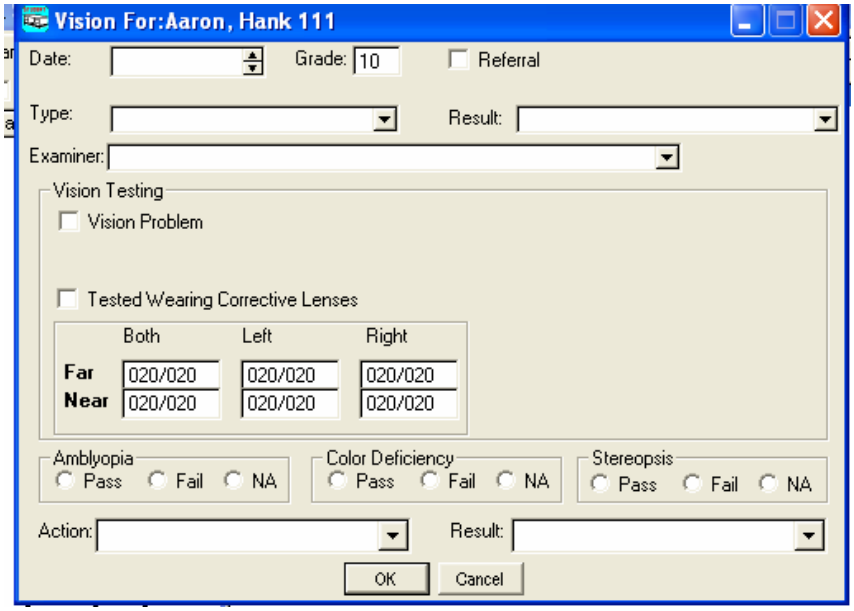
Exam Date: Enter the physical exam date at initial entry and entrance into sixth grade

Grade: Enter the grade the student was in when exam given

*All other fields are optional for data entry

Vision Exam Information

(Initial Entry)



Initial Entry into school Vision Exam – must be completed before January 1 of current school year.

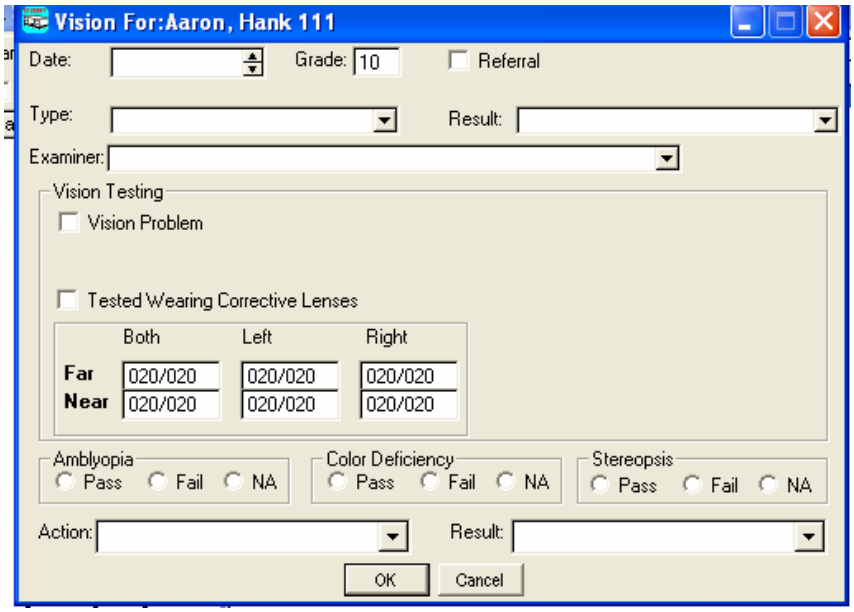
Date: Enter the Vision Exam date

Type: Select Vision Exam from the drop down menu

*All other fields are optional for data entry

Vision Screening Information

(Districts determine which grades will have annual screenings as per 704 KAR 4:020)



Date: Enter the Vision Screening date

Type: Select Vision Screening from the drop down menu

Results: Select results of vision screening from drop down menu; passed, failed, cannot test or refused

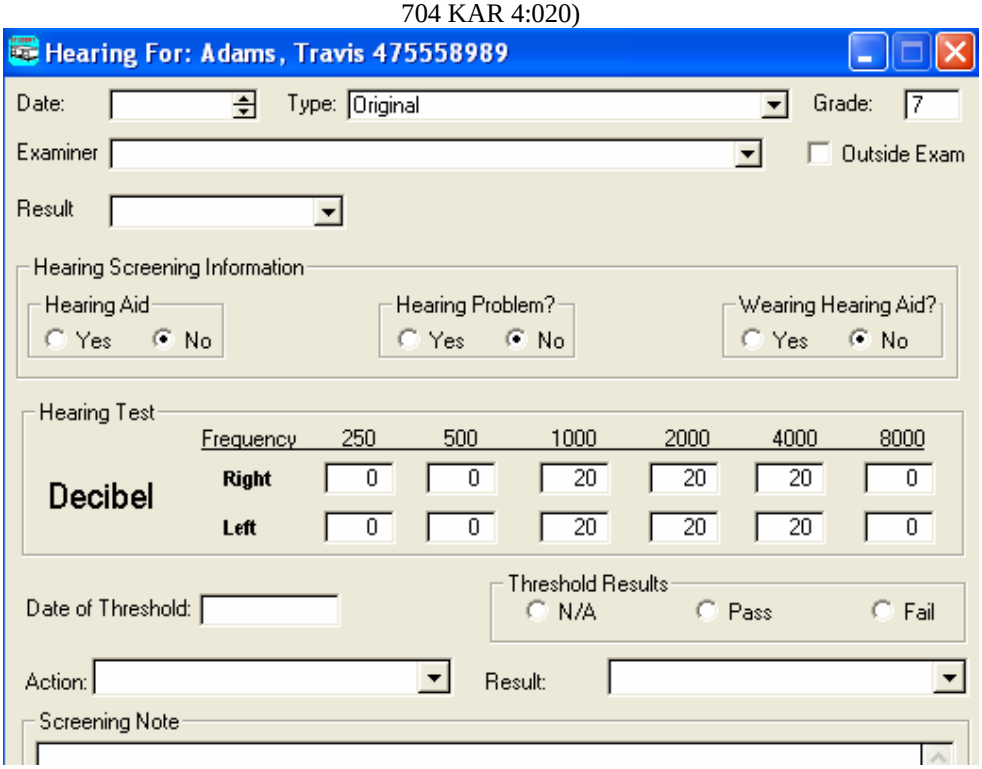
Vision Screening Referral Checkbox: If student failed the Vision Screening, you must select the Referral checkbox and enter the date the referral was made

Referral Date: Date in which notice sent to parent that student failed the vision screening and needs to be seen by a doctor

*All other fields are optional for data entry

Hearing Screening Information

(Districts determine which grades will have annual screenings as per 704 KAR 4:020)



Date: Enter the Hearing Screening date

Type: Select Original from drop down menu

Results: Select results of hearing screening from drop down menu; passed, failed, cannot test or refused

If original screening failed, Re-screening requirements:

Type: Select Re-Screen from drop down menu

Date: Enter the date of hearing re-screening

Results: Select results of hearing re-screening from drop down menu; passed, failed, cannot test or refused

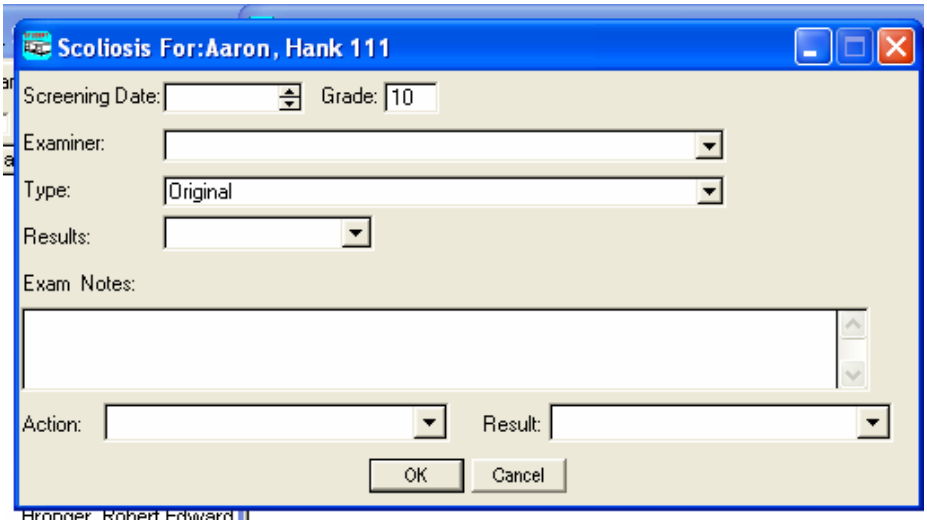
If student fails a Hearing Screening or Re-Screen, then a Referral needs to be made, those requirements:

Type: Select Referral from drop down menu

Date: Enter the date referral was made

Scoliosis Screening Information

(6th and 8th Grade Only)



Screening Date: Enter the date of scoliosis screening for grades 6 and 8

Type: Select Original from drop down menu

Results: Select from drop down menu the results of the scoliosis screening, Pass, Fail, Absent, Refused, Cannot Test, Known Previously, and Referral

---

****All failures must be referred**

Criteria for Referral

The following criteria for referral is used by second screeners as a guide on which to base referrals. If any child has any three of the following, the child should be referred to a pediatrician, family doctor, or the Commission for Children with Special Health Care Needs (CCSHCN).

1. One shoulder higher than the other
2. One scapula more prominent than the other
3. Waist folds not even
4. Arms not hanging equal distance from the sides
5. Pelvis not level
6. Unequal symmetry of the upper back, lower back or both

If any one or two of the above are seen, then the child should be re-screened in 6-12 months. If the child, on forward bend test, has a hump on one side hat measures less than 7 degrees, using the scoliometer, the child should be re-screened in 6-12 months.

Any student with possible indicator must be re-screened

If re-screening performed:

Re-screening Date: Enter the date of scoliosis re-screening and results

Type: Select Re-Screen from drop down menu

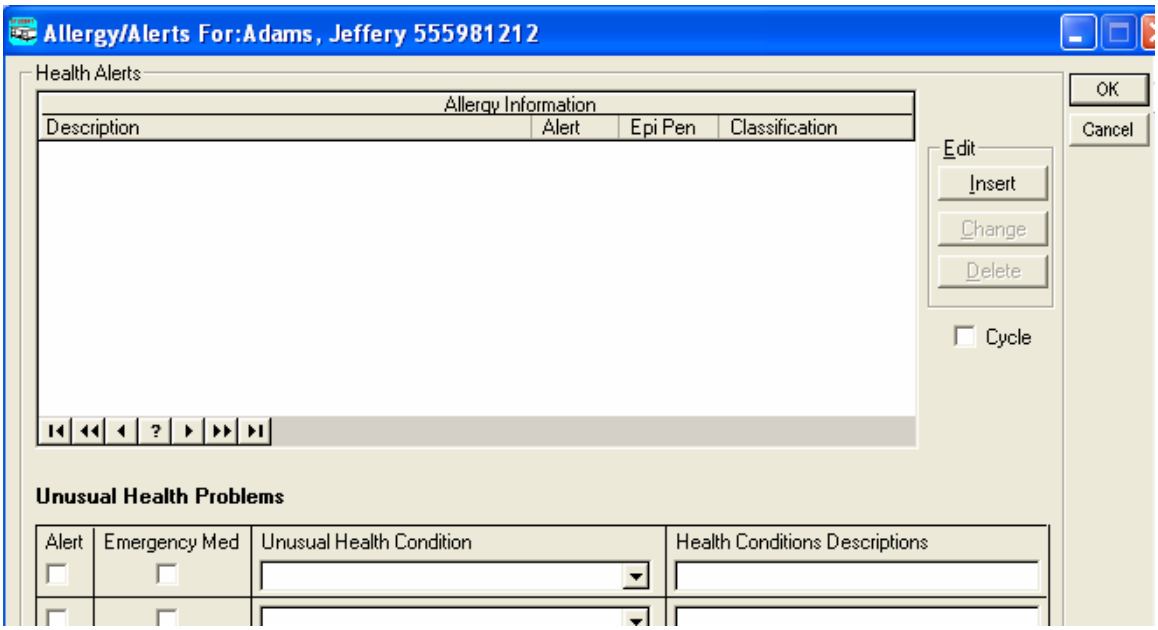
Results: Select Passed or Referral (if student failed)

Allergy/Alert

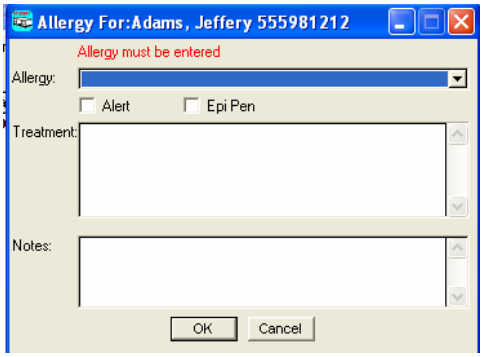
An alert is any medical condition that will require an emergency action. If alert is selected on the Allergy data entry screen or beside an Unusual Health Condition, this data will be written to SITClassroom; STIOffice; STIDistrict and STIDistrictHealth.

This data is usually collected from a student's parent/guardian from one of the following forms:

- Emergency Information Form
- Health History Form
- Individual Health Plan
- Medication Request Form
- KSBA Personal Data Sheet 09.224 AP

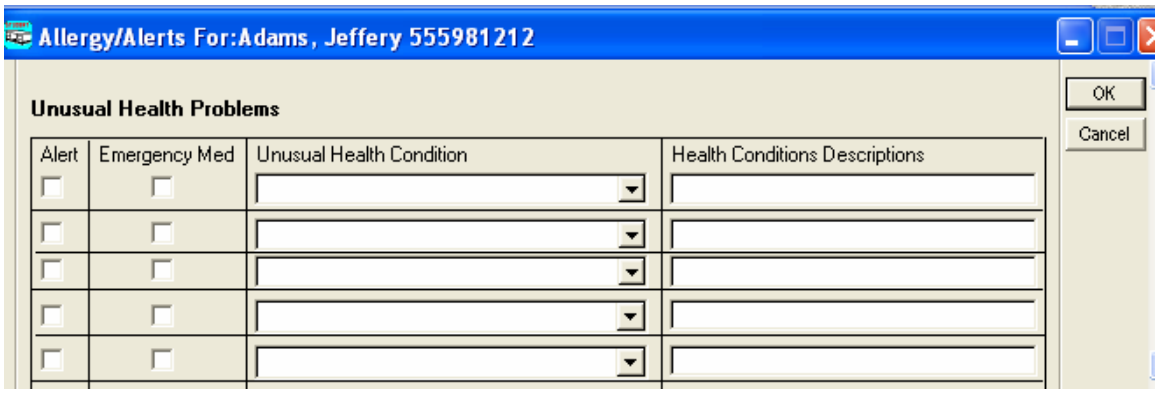


Allergy Data Entry



Allergy: Select specific allergy from drop down menu
Alert: Select indicator if specified allergy requires emergency action
EpiPen: Select indicator if specified allergy requires EpiPen administration
Notes: Specify detail of Allergy and EpiPen administration, i.e., Peanut Allergy student develops respiratory distress. Has been trained and can carry and self-inject EpiPen.

Unusual Health Conditions



Alert: Select indicator if specified health condition requires scheduled or emergency action
Emergency Med: Select indicator if specified health condition requires emergency medication administration. This data is usually collected from a student's parent/guardian from one of the following forms:

- Emergency Information Form
- Health History Form
- Individual Health Plan
- Medication Request Form
- KSBA Personal Data Sheet 09.224 AP

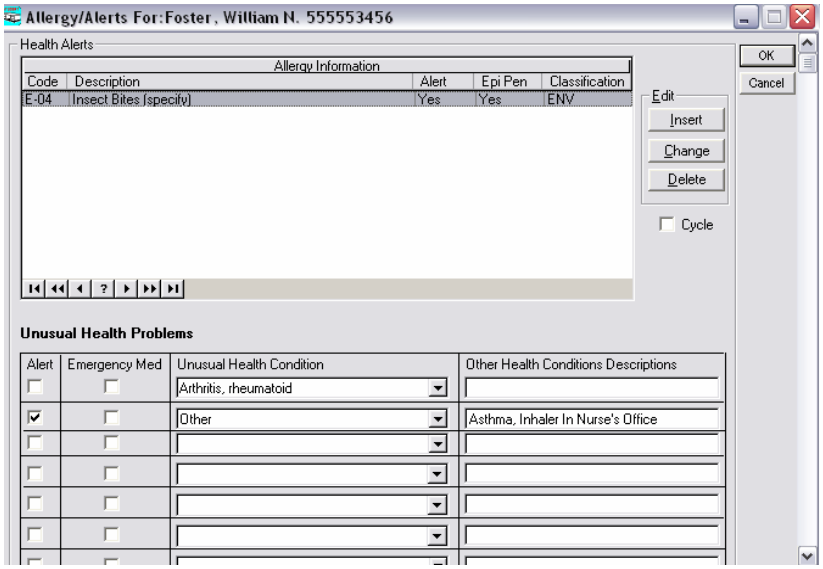
Unusual Health Condition: Any condition that requires a scheduled action during the instructional day. Please choose from the drop down menu the Health Condition for student
Health Condition Description: Any brief description of treatment or clarification of health condition

Changes and Updates

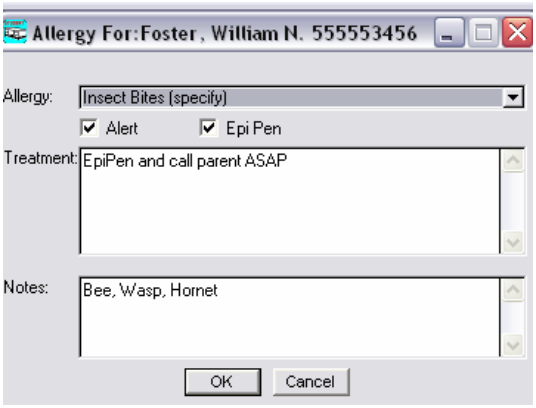
Allergy/Alert

Reminder!!! Users MUST go to Utilities | Utility Window | Move Alert Messages, to move Alert Messages and Unusual Health Problems from "Medical" to "Allergies/Alerts BEFORE entering any Allergy, Health Alert or Unusual Health Condition data.

Access this button from the Add/Edit Desktop or the Student Desktop. From this button the user will be able to access Allergies, Alerts, and Unusual Health Conditions in an efficient manner.



The top portion of this screen contains information pertaining to Allergies. The user can indicate the Allergy, Treatment, Notes, whether an Alert is necessary and if the student requires an Epi-Pen.



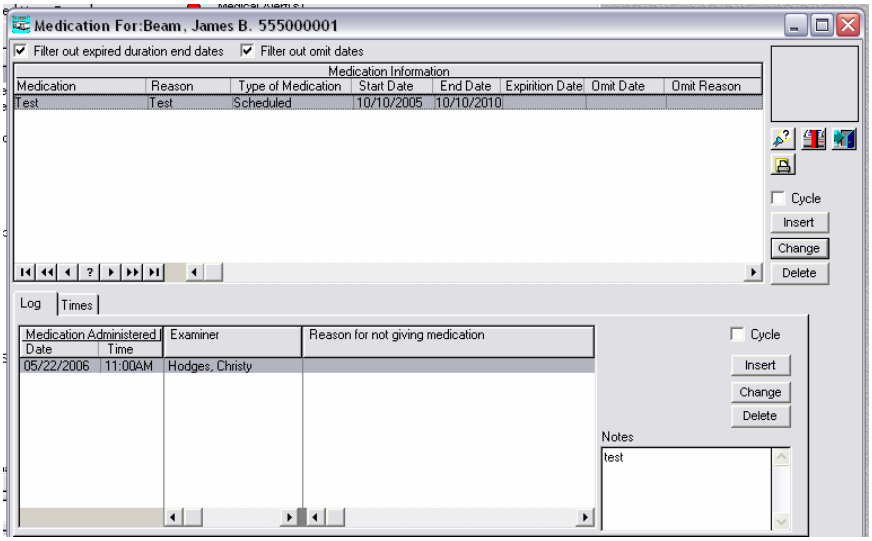
- Allergy: is selected from the drop down.
- Alert: This checkbox can be selected if the Allergy is an Alert for the student, if selected the Allergy will be visible in STIOffice and STIClassroom.
- Epi Pen: If the student requires an Epi-Pen for the Allergy, select this checkbox.
- Treatment: If any specific treatment is necessary it can be entered in this textbox.
- Notes: Any other important information can be entered in this textbox.

The lower portion of the screen is used for tracking Unusual Health Conditions.

- Alert: This checkbox allows the user to indicate that the health issue is an Alert, if selected the health condition will be visible in STIOffice and STIClassroom.
- Emergency Med: This checkbox indicates that there is an emergency medication to address this specific health problem.
- Unusual Health Condition: The user can select the Unusual Health Condition from this list.
- Health Condition Descriptions: The user can enter any information regarding the health condition here. This is especially useful when "Other" is selected as the Unusual Health Condition. If Emergency Med is selected, it is recommended that the medication/treatment be entered in this text box.

Medication

Medication information for students can be tracked on this screen.



The top portion of this screen contains details from the medication itself, while the bottom portion of the screen contains information regarding the administration of the medication.

Only medications that are active will appear on the Medication screen, other medications can be shown by using the filters at the top of the screen. Also, logs and times can only be entered on active medications. The user can select to only see the Emergency Medications for a particular student by selecting the appropriate checkbox.

Medication and Reason

- Click the **Medication** button to add a medication item to a student's record.
- Click **Insert** in the upper middle section of the screen to access the Update Records menu. Enter the appropriate information in the fields provided. Most of the data fields are self-explanatory. Following are some possible exceptions:
  - Medication: Enter the name of the medication; for example, *Ritalin*. (The user may select from Medication Codes by clicking  and selecting the appropriate medication.
  - Reason: Enter the reason the student is taking the medication or click  and select the appropriate reason.

- Type of Medication: Select from the drop-down list if the medication is *Emergency*, *Over-the-Counter*, *Prescription* or *Scheduled*. (Scheduled must be selected in order for the medication to print on the *Medication Checklist Report*.
- Administered By: Select from the drop-down list if the medication is *Supervised Self-Medication* or *Unsupervised Self-Medication*.
- Expiration Date: If Emergency is selected as the "Type" the expiration date of that medication must be entered.
- Dosage: Enter the dosage amount. For example, *2 tablets*.
- Frequency: Enter the dosage frequency. For example, *2x/Day* for two times per day.
- Start Date: Enter the start date of the medication.
- End Date: Enter the end date of the medication.
- Parent Written Authorization: Check box if the student's parents have given written authorization for the student to receive medication.
- Parent Sign Date: Enter the date the authorization was received in this field.
- Physicians Written Request: Check this box if the student's physician issued a written statement requesting that the student receive medication. Enter the date the statement was received in the *Physician Written Request Date* field below.

- Click **OK** to save.

Note: Once medication information has been saved, it is not editable. The only information that may be entered is "Omit" information. If a medication order is changed a new Medication entry needs to be completed.

Medication Times

- This tab, located in the bottom part of the menu, may be used for two different purposes. If the medication is to be administered on a *scheduled* basis, enter a regular time at which the medication is to be administered. If the medication is to be administered on an *emergency* basis, enter the specific time following the emergency at which it was administered.
- If more than one medication is listed in the Medication browse box, make sure the correct one is highlighted. Click **Insert** in the bottom right corner to add a Medication Time.
- Enter the *Administered Time*. Additional notes may be entered in the field provided.
- Click **OK** to save.

Medication Log

- This field may be used in conjunction with *Medication Times* to keep track of *scheduled* medications. The scheduled time would be entered under *Medication Times*. The actual date and time of each medication administration would be entered under *Medication Log*.
- If more than one medication is listed in the Medication browse box, make sure the correct one is highlighted. Click **Insert** below the Medication Log browse box to add a *Medication Time*.
- Enter the date and time at which the medication was administered.
- For *Examiner*, use the drop-down arrow to select the employee who administered the medication. Enter any notes in the field provided.
- Click **OK** to save.

Printing Medication Reports

Two printer icons are displayed in the Medication menu:

- Click the  icon to generate a report listing the following: Medication; Reason; Type of Medication (i.e., Scheduled or Emergency); and Start and End Date.
- Click the  icon to generate a detailed report of the above information as well as dosage details and physician, pharmacy and parent information.

STIOffice View Window

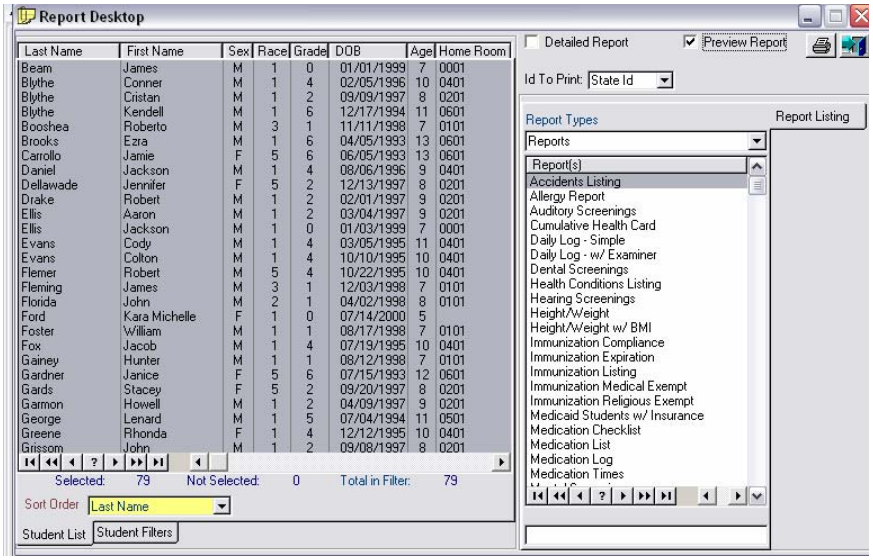
Click the  icon to access "View Only" information from STIOffice. This will allow view of student's demographic, emergency contact and discipline information. F4 will show student's daily schedule and F8 will show student's attendance records.

Student Health Profile

The  icon allows the user to quickly view Health information for the selected student.

Information contained on this screen includes: Screenings and General Medical, Daily Log, Medication, Immunizations, and Allergy/Alerts. This information is view only.

Reports



The user now has the option of selecting which of the student's identification numbers will print on the report. This selection needs to be made before the user uses any of the filtering/sorting/student selecting options.

- The 'Id to Print' options include:
  - State ID (recommended)
  - Student ID

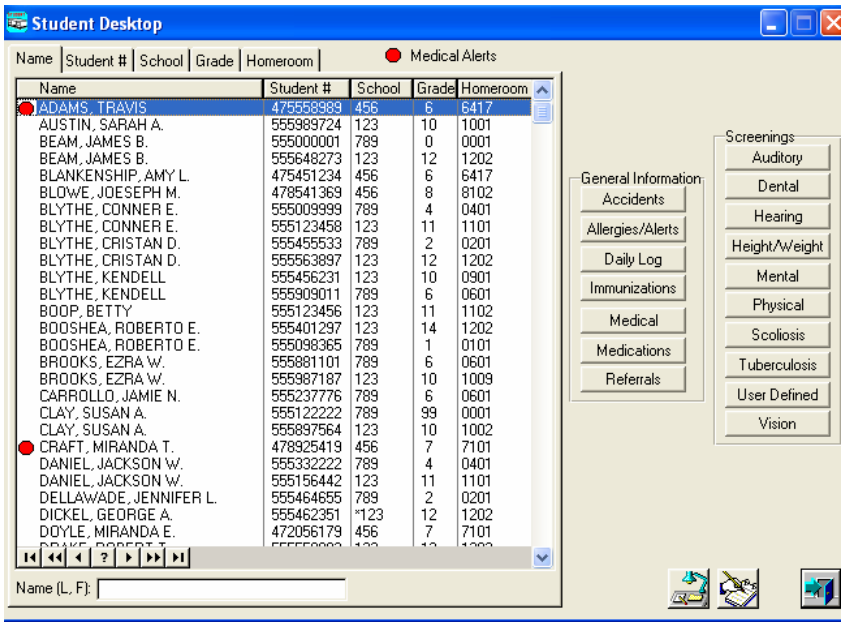
- Social Security
- None

Immunization Compliance

- The “Shot Compliance” report has been renamed to “Immunization Compliance”.
- The “Detailed Immunization Compliance” report now includes all shot dates.
  - Shot types with dates falling within the regulation will print in a normal font.
  - Shot types with dates falling outside of the regulation will print in bold font.
  - Shot types with no shot dates entered will print in bold font.
  - Certificate Type has been added to the report.
  - Students who are Religious Exempt will appear with two asterisks (**) to the left of their name.
  - Students who are Medical Exempt will appear with one asterisk (*) to the left of their name.
  - Medical Exempt Notes will appear on the report if entered.

District Health Changes and Updates

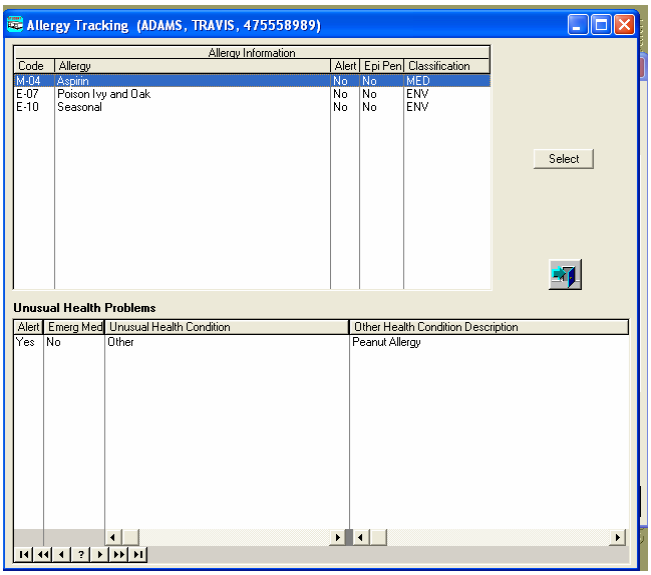
Student Desktop



Users now have the option to sort students by Name, Student #, School, Grade, and Homeroom. The users can also use the lookup feature to quickly find students.

If students have an “Alert” the red indicator will appear on the desktop.

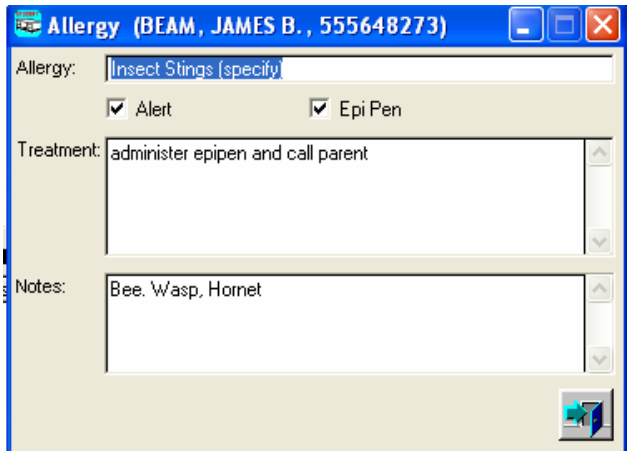
Allergies/Alerts



The top portion of the screen includes information pertaining to Allergies. The browser window includes:

- Allergy: What the student is allergic to.
- Alert: If the Allergy is indicated as an Alert "Yes" will display, if the Allergy is not an Alert, "No" will display.
- Epi-Pen: If the student requires an Epi-Pen for the allergy listed "Yes" will display.
- Classification: The "type" of Allergy, (i.e. Food, Environmental, Medical).

The user can highlight the Allergy and click "Select" and view information regarding the Allergy. Any notes typed in the "Treatment" or "Notes" textbox will display.

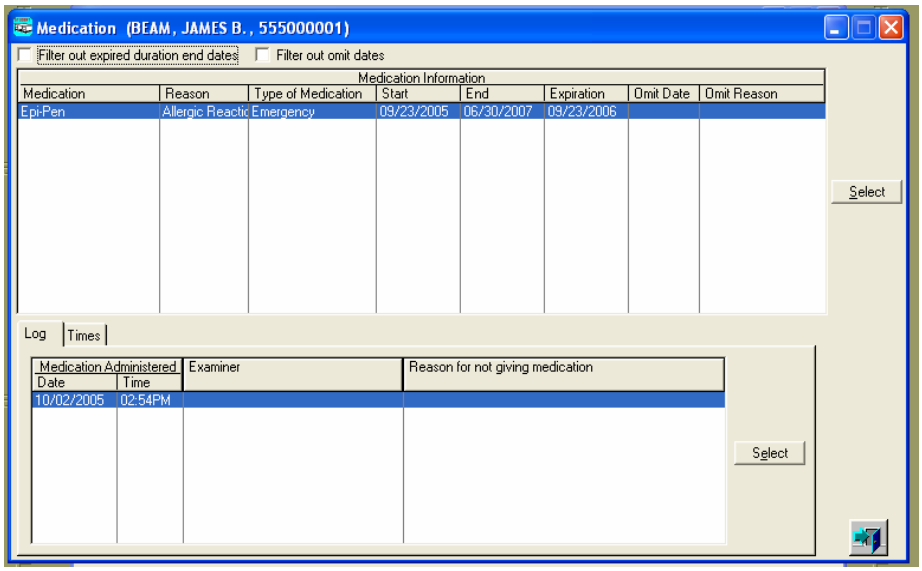


The lower portion of the screen is used for Unusual Health Conditions. The browser window includes:

- Alert: It the Health Condition is indicated to be an Alert, "Yes" will display here, if the condition is not an Alert, "No" will be displayed.
- EmergMed: If the Emergency Medication indicator is selected "Yes" will display here, if there is no Emergency Medication indicator, "No" will be displayed.
- Unusual Health Condition: This field will indicate the actual Health Problem associated with the student.

- Health Condition Description: Any additional information that has been entered regarding the Health Condition can be viewed here. This might include more specific information about the Health Condition or Treatment information.

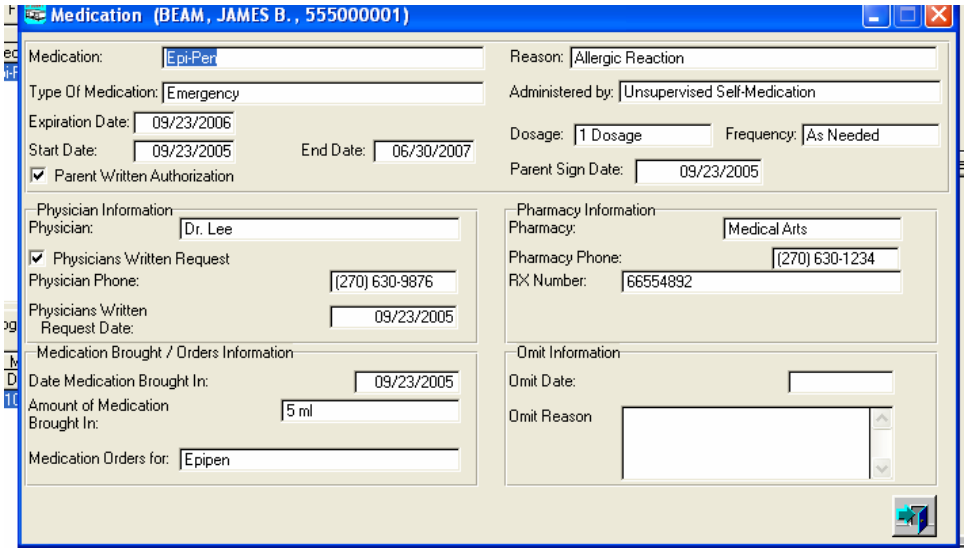
Medication



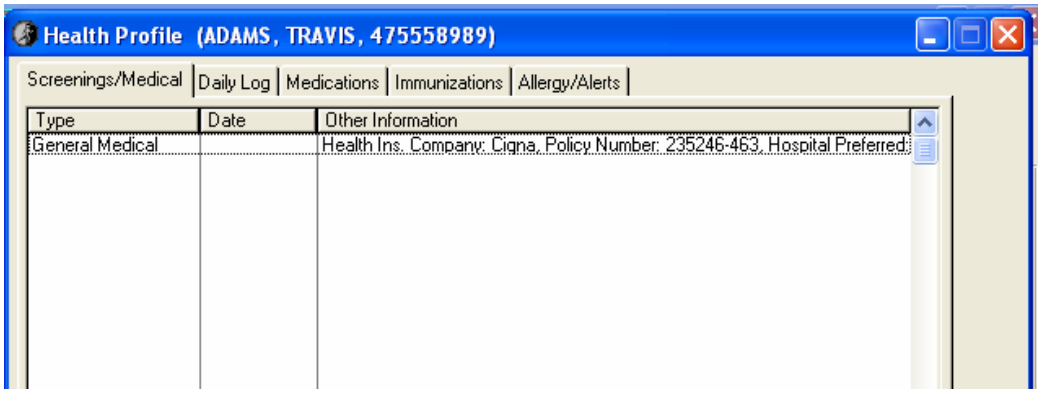
Medication information can be viewed on this screen.

"Expiration" has been added to the browse window (the date will display for Emergency Medications only).

The "View" button will allow the user to see all of the information entered pertaining to the selected Medication. ("Expiation Date" will only be populated when "Emergency" is selected as the "Type of Medication"

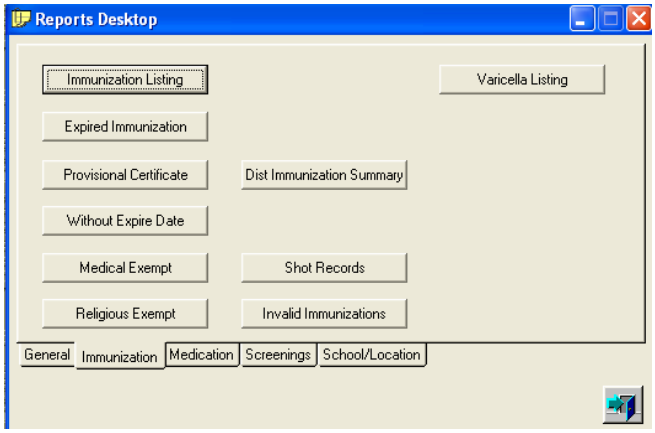


Student Profile



The Student Profile allows users to have a quick view of all Health Information entered for students. Five tabs contain this information: Screenings/Medical, Daily Log, Medications, Immunizations, and Allergy/Alerts.

Report Desktop



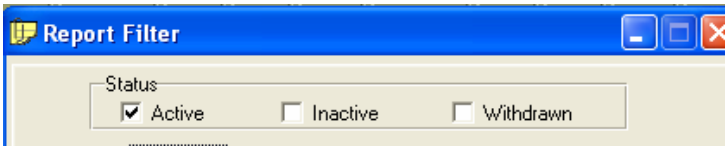
All District-wide Health reports can be generated from this desktop, there are 5 categories indicated on the Tabs at the bottom of the report desktop. (Reports in **Bold** are new for 2006-2007):

- General:
  - Accident Listing
  - Alert Messages
  - Allergy Listing
  - Daily Log
  - Health Conditions Listing
  - **Health Condition Report** (When this report is generated, health_condition.txt will be created and saved in the daisi2 folder on the workstation running the report.)
  - Referral
  - **Student Health Report** (This report includes Immunization Compliance, Certificate Type, Shot Totals, Vision Exam, Physical, and Vision, Scoliosis, Hearing Screening Information.)
- Immunization:
  - Immunization Listing
  - Expired Certificate
  - Provisional Certificate
  - Without Expire Date

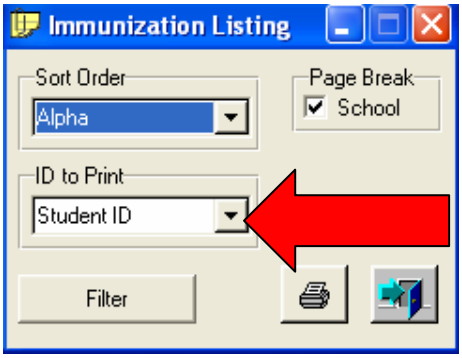
    - Medical Exempt
    - Religious Exempt
    - Dist. Immunization Summary
    - Shot Records
    - Invalid Immunizations
    - **Varicella Listing** (This report has the option to print a list of students who have had Varicella, or a list of students who have not had Varicella.)
- Medication
    - Medication Listing
    - Medication Log
    - Med. Times to Administer
- Screenings
    - Auditory
    - Dental
    - Hearing
    - Height/Weight
    - Mental
    - Physical
    - Scoliosis
    - Tuberculosis
    - User Defined
    - Vision
- School/Location
    - Schools/Locations
    - Employee Types
    - Employees/Service Provider

Filter Options

Reports will include Active students only (the user can chose to include Inactive or Withdrawn students by checking the appropriate check boxes under Filter.
N

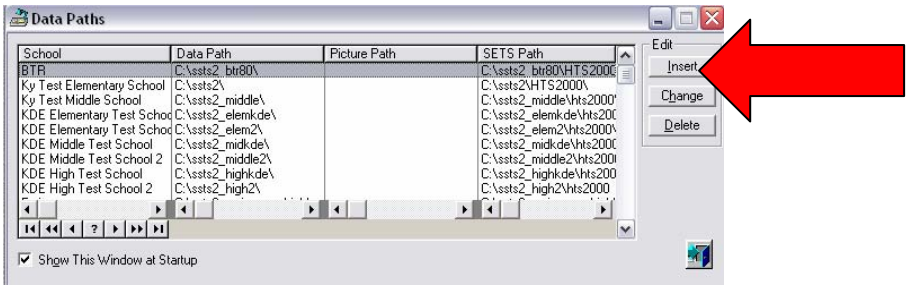


Users will have an option to select the ID they want to print on the reports that include student listings.

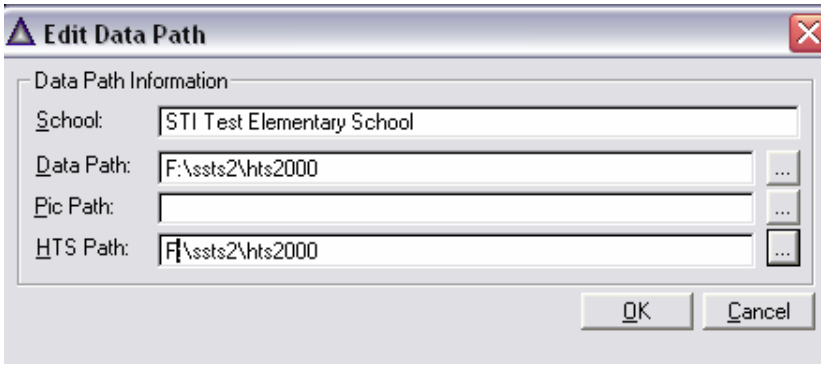


Multiple Data Path Setup

(This is useful when a user needs to access multiple schools' information from a single workstation.)
Go into Utilities | Utility Window | Manage Data paths.



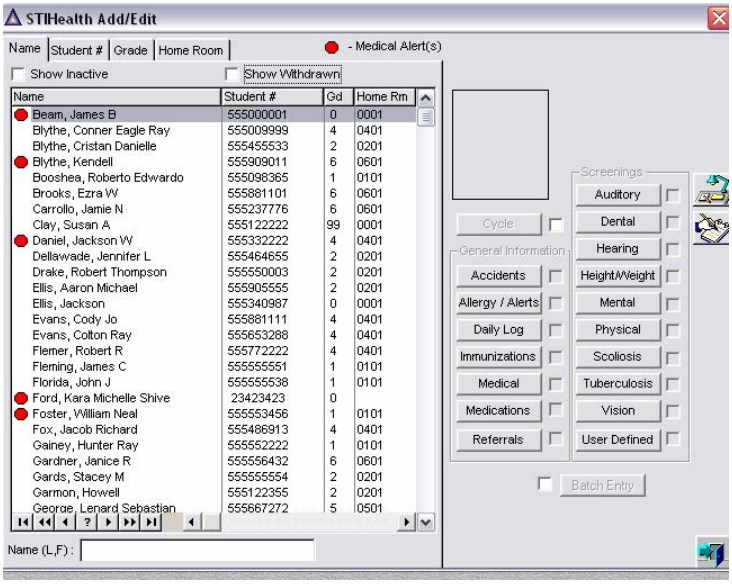
Click "Insert," then enter the appropriate data paths (use the ellipsis […] button to browse for the data path).



Click "OK" once the information has been entered.

Add/Edit Student Information Desktop

Click the  icon to enter or change student health information.



The **Student Add/Edit Desktop** allows the user to enter the information for single or multiple students. The desktop also allows the user to *Cycle* though selected students or create a Batch Entry for screenings for multiple students.

Cycle

Cycling will allow the user to go immediately from one student to the next after entering the selected data for each student. Follow these steps to use the cycle feature:

- Select the checkbox to the right of the *Cycle* button.
- Select the students for whom records are to be added. Students can be selected by clicking each student individually or by right clicking and choosing **Select All** to select all students; **Reverse** to transpose the selection of students; or **Clear** to de-select all students.
- The user may select groups of students based on Grade. Follow these steps to select all students in a particular grade.
    - Select the *Grade* tab at the top of the *Add/Edit* screen
    - Place the cursor on a student in the desired grade or homeroom and right click.
    - Chose **Select All** Grade (#) Students.
    - All students in the desired grade will be selected
- The user may also choose to select all of the students in a particular homeroom. Follow these steps to do this:
    - Select the *Homeroom* tab.
    - Place the cursor on a student who is in the desired homeroom and right click.
    - Chose **Select All** Students in Homeroom (#).
    - All students in that homeroom will be selected.

- After the students have been selected, the user may then select the *General Information and/or Screening* option to add for the students. To do this, simply check the box to the right of each button for the information that needs to be entered.
- After selecting the information to add, click the *Cycle* box.
- The cycle will take the user through each of the input screens one student at a time.
- The user will enter information for the student just as in the student desktop, using **Insert**, **Change** and **Delete** to modify student records.
- Once the user has cycled through the selected screens for the student, the program will cycle to the next student selected, and will continue through each selected screen. This will continue until all students have cycled.

Cycle Feature within Status Windows

- In most all of the *General Information* and the *Screenings* status windows, the user will have the option to *Cycle* to complete multiple records. If this is selected once the user inserts a record and clicks **OK**, that record will be saved and then a new blank record will open. This saves the user from having to go back to the status window to click **Insert** for each new record.

  Note: The program will continue to cycle until the user selects **Cancel** at the bottom of the record.

- An example of when this feature would be valuable might include *Allergies*. If a student has multiple allergies, the cycle option will allow the user to enter as many allergies as needed eliminating the added steps of having to click insert for each allergy.

Batch Entry

Choose this option to enter screening data for multiple students (a *batch* of students) at one time. To use this option, select the *Batch Entry* checkbox and then choose the students who are to be included in the batch. There are different ways in which to select students:

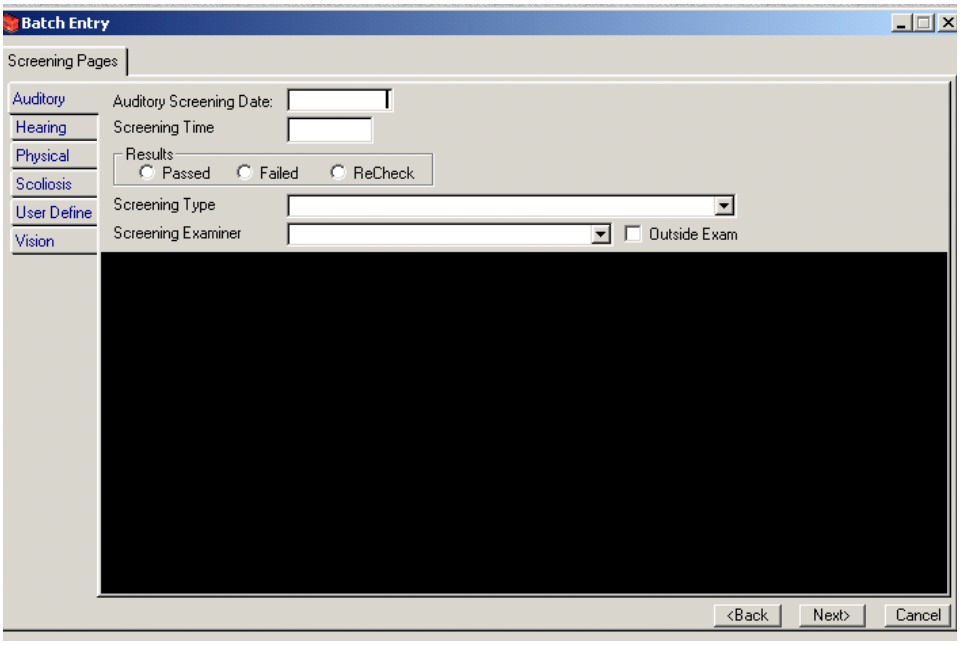
- Students may be selected by clicking each student individually or by right clicking and choosing **Select All** to select all students; **Reverse** to transpose the selection of students; or **Clear** to de-select all students.
- The use may select groups of students based on Grade. Follow these steps to select all students in a particular grade.
  - Select the *Grade* tab at the top of the *Add/Edit* screen
  - Place the cursor on a student in the desired grade or homeroom and right click.
  - Chose **Select All** Grade (#) Students.
  - All students in the desired grade will be selected.
- The user may also choose to select all of the students in a particular homeroom. Follow these steps to select all students in a particular homeroom.
  - Select the *Homeroom* tab.
  - Place the cursor on a student who is in the desired homeroom and right click.
  - Chose **Select All** Students in Homeroom (#).
  - All students in that homeroom will be selected.

    - Click the **Batch Entry** button

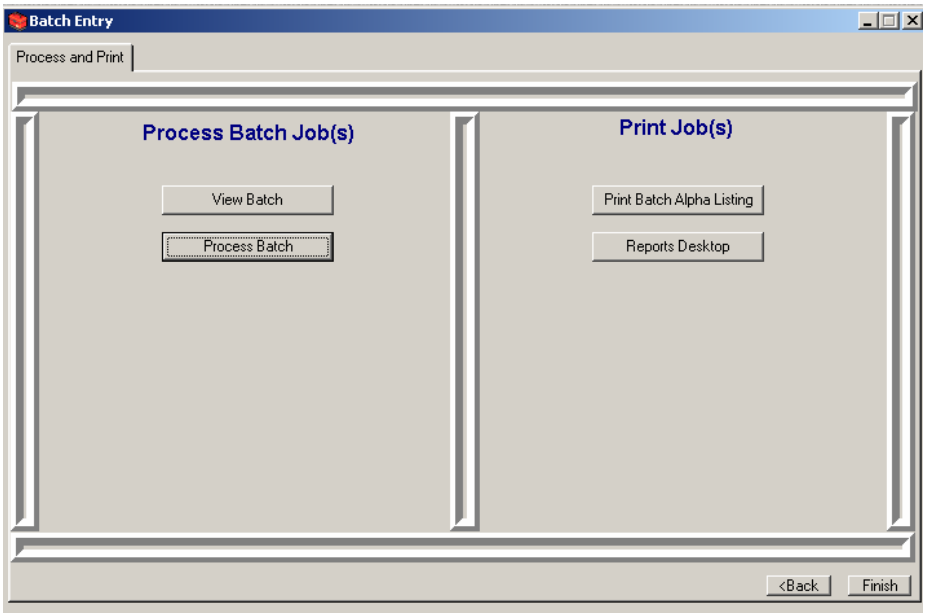
- If desired, use the drop-down arrows to select the employee who examined the student(s), the specific *Action* taken, and the *Result*. Click **Next** to continue.

  Note: It is not necessary to enter this information; the user may simply click **Next** to continue.

- The *Screening Pages* menu will appear. Six tabs down the left side of the screen are available for selection of the various screening options. Select the appropriate screening(s) and enter the data in the fields provided. Click **Next** to continue.



- The *Process and Print* menu will appear. Four options are available here:



  - **View Batch**: Select this option to view a list of all students included in the batch selected above. Students will be displayed in a browse box, along with some basic demographic information.
  - **Process Batch**: Select this option to process the screening information entered above.
  - **Print Batch Alpha Listing**: Choose this option to generate a report displaying all students included in the batch selected above.

- **Reports Desktop**: Choose this option to access the *Reports Desktop* menu.
- Click **Finish** to complete the procedure. **(Note: In order to save the Batch information Process Batch MUST be selected before clicking Finish.)**

Medical

- Click the **Medical** button, then click **Insert** to create a record or click **Change** to modify the existing record. Note that two different types of reports may be generated here: *Student Medical Information* and *Student Medicaid Information.*
- Select **Change** or **Insert**.
- The following information is entered in this screen:
  - Birth Certificate Number: The student's birth certificate number will auto-populate from STIOffice if the information is entered there. If there is not information entered in STIOffice for this field the user can entered the Birth Certificate Number, however if a different number is later entered in STIOffice it will overwrite the number entered in STIHealth.
  - Medicaid ID Number: The student's assigned Medicaid ID Number.
  - Medicaid Services: Months in which the student has had services.
- The following information may also be entered here:
  - Seek Medical Assistance As Needed: Check *Yes* if authorization has been obtained to seek medical assistance for the student
  - Administer: Check *Yes* if authorization has been obtained to administer any treatment deemed necessary by the physician.
  - Other Suggestions: Enter any other medical options in this field.
  - Insurance Information: Enter the students' appropriate health insurance information in the spaces provided.
  - Indicate whether the student has School Insurance
  - Enter Special Health Notes
- After entering all of the appropriate information, click **OK** to save.

Accident Report

This option "feeds" into the student's Daily Log record. In other words, once an Accident Report has been created, an entry will also be made in the Daily Log.

- Click the **Accident Report** button and then click **Insert** to create an Accident or Incident Report.
- The *Report Date* and *Incident Time* will default to the current date and time. The user may change either of these fields by double-clicking on them.
- The data fields in Accident Report include:
  - Contributing Factors: The user may type information or select  to use codes already entered as Contributing Factors.
  - Injured Body Parts: If this applies type information or use  to select from a list of previously entered codes.
  - Reported - Teacher / Examiner: Use the drop-down arrow to select the name of the employee who reports or oversees the incident.

- Who was in Charge: Use the drop-down arrow to select the name of the employee who was in charge of the student when the accident occurred.
- Property Damage: Indicate Yes or No if desired.
- From Athletics: Select Yes or No if desired.
- At Scene: Indicate if the teacher was at the scene when the accident occurred.
- Place of Incident: Enter the place of the incident or use the  icon to select the place that the incident occurred.
- Nature of Injury: Enter text or use the  icon to select from a list.
- Type of Activity: Type the nature of activity or click the  icon to select.
- Notes: Type any additional information relevant to the accident.
- Action: Use the drop-down arrow to select the action taken to resolve the incident.
- Result: Use the drop-down arrow to select the ultimate result of the incident.

- Click **OK** to save.

Daily Log

Three data fields are used in the Daily Log menu. The following steps must be performed in the order in which they are listed.

Items entered in the Daily Log may or may not refer to a specific *Accident / Incident Report,* at the user's discretion.

Note: When an entry is created in the Accident Report, this information will be added in the Daily Log.

Creating the Log Incident

- Click the **Daily Log** button to add an item to the student's Daily Log.
- Click **Insert** in the upper middle section of the menu.
- The date and time will default to the current date and time. The user may change either of these fields by double-clicking on them. *Time Out* refers to the time the student was released.
- Use the drop-down arrows to select a *Symptom, Treatment* action, *Outcome, Referred By* employee and *Examiner* employee.
- Check *Re-exam* or *Call Parent* (at the top of the screen) if appropriate.
- If this log entry refers to a specific Accident / Incident Report (the report must have been created before the Daily Log may refer to it), use the drop-down arrow under *Accident / Incident Report* to select the correct item. Check *Incident Report* if appropriate.
- Enter *Note* if desired.
- Click **OK** to save and return to the Daily Log menu. At this point, Log Notes and/or Doctor Notes may be entered for this record.

Log Notes

- Make sure the correct Log Incident is highlighted in the upper browse box, and that the Log Notes tab is selected in the lower browse box, then click **Insert** to the right of the *Log Notes* browse box to add more detailed notes.
- The date and time listed here will automatically be copied over from the *Date* and *Time In* fields in the original *Log Incident* (above).
- Enter a *Note Category* in the space provided.
- Check *Note Status* to exclude the note from view.
- Enter any notes in the space provided.
- Use the drop-down arrows to select an *Action* and an *Outcome*
- Click **OK** to save.

Doctor Notes

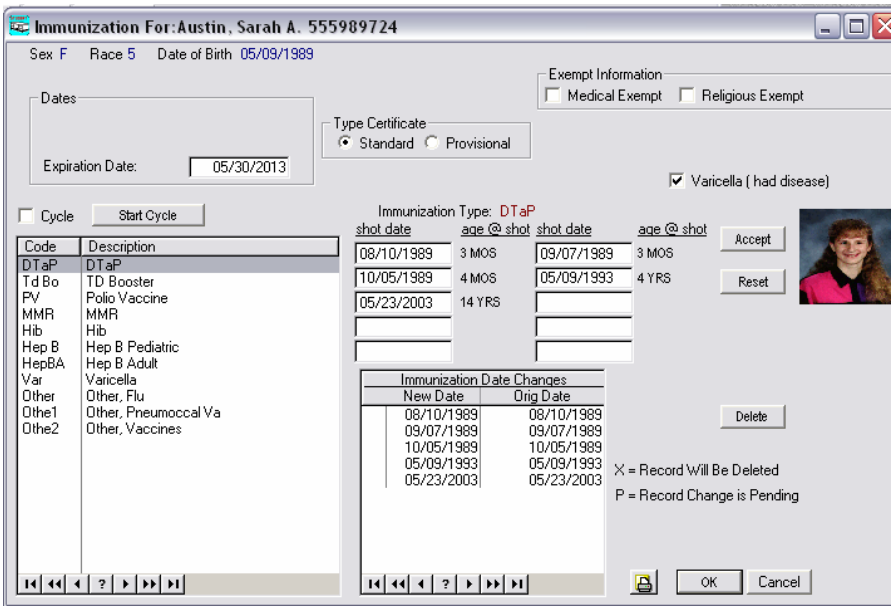
- Click **Insert** below the *Doctor Notes* browse box to add any notes from the doctor.
- The date and time listed here will automatically be copied over from the *Date* and *Time In* fields in the original *Log Incident* (above).
- Enter the *Shift* in the space provided.
- Enter any patient chart notes in the space provided.
- Click **OK** to save.
- Click the  icon to generate a Daily Log Listing as it will appear in the Daily Log under **Inquiry Desktop**. Note: All "note" entries now print on a daily log report.

Note: Log Notes and Doctor Notes **do not** print.

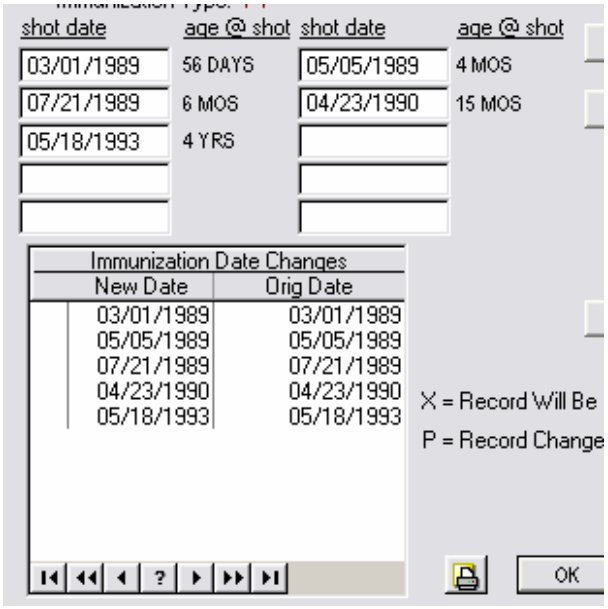
Immunization

The immunization screen includes information about both the student's immunization certificate and their individual shot records.

Click the **Immunizations** button to access the Immunization menu.



- Enter the appropriate information in the fields provided:
  - Exempt Information: Mark if the student is Medical Exempt or Religious Exempt.
    - If the student is marked Medical Exempt, a text box will appear for notes regarding the exemption. It is recommended that the user specify which shot(s) the student is exempt from in this field.
    - If the student is marked Religious Exempt the Expiration Date box will be removed from the screen.
  - Expiration Date: Enter the Expiration date that applies to the student's Immunization Certificate.
  - Type Certificate: Select if the certificate is *Standard* or *Provisional* under *Type Certificate*. *Note: This information must be selected before exiting the Immunization screen.*
  - Varicella: Check box if the student has had the "Chicken Pox" disease.
  - Immunizations: Select on the list from the left which shot should be added. The immunization type that has been selected will also be indicated in the Immunization Type (in the middle of the screen). In the boxes below *Immunization Type*, enter the student's shot dates for the immunization selected and click **Accept**. The shot date will appear in the *Immunization Date Changes* window.
  - Age @ Shot: Displays the age of the student on that shot date. This is an aid for users when reviewing reasoning behind students being non-compliant in their immunizations. (Allows user to figure out which shot was given out of the regulations without having to calculate the students' age(s).)



Note: The **Accept** button must be selected in order to save pending shot dates to student records.

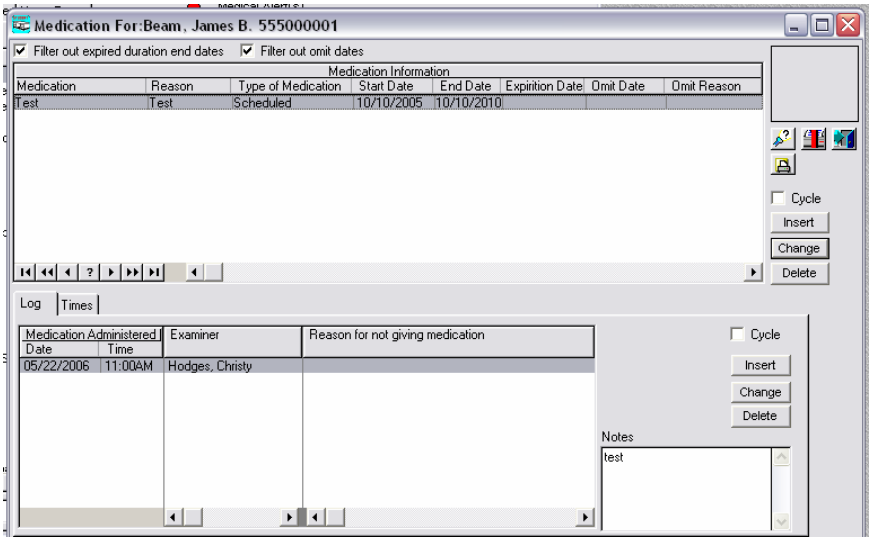
- If a mistake is made when entering the dates, click the **Reset** button. This will reset the shot dates to what they were before the user started entering information.
- If it is necessary to delete a record from the *Immunization Date Changes* window, select the record that needs to be deleted and click the **Delete** button.
- Shot Status:
  - When a shot date is listed in the Immunization Date Changes the status will be at P for pending. After clicking OK the record will be moved from pending status.
  - When a shot date is listed in the Immunization Date Changes the status will be an **X** for delete. The record will be deleted when the user selects **OK**.
- Cycle Feature: The user also has the option to cycle through the shots that need to be inserted for a particular student. The cycle will sequence through the selected shots for the student to allow the user a quick way to enter shot information. To use the cycle feature, follow these steps:
  - Select the *Cycle* checkbox.
  - Choose all of the shots for which dates are to be entered by simply clicking on the shot code or description.
  - Click the **Start Cycle** button.
  - The name of the current shot will appear in the *Immunization Type* field. Enter all of the shot dates for this shot type and click **Accept**.
  - The next immunization code will appear as the *Immunization Type*. Enter the shot dates and click **Accept**.
  - Repeat until all records have been added.

Printing Immunization Records

To print the student's immunization information, click the  icon.

Medication

Medication information for students can be tracked here.



The top portion of this screen contains details from the medication itself, while the bottom portion of the screen contains information regarding the administration of the medication.

Only medications that are active will appear on the Medication screen, other medications can be shown by using the filters at the top of the screen. Also, logs and times can only be entered on active medications. The user can select to only see the Emergency Medications for a particular student by selecting the appropriate checkbox.

Medication and Reason

- Click the **Medication** button to add a medication item to a student's record.
- Click **Insert** in the upper middle section of the screen to access the Update Records menu. Enter the appropriate information in the fields provided. Most of the data fields are self-explanatory. Following are some possible exceptions:
  - Medication: Enter the name of the medication; for example, *Ritalin*. (The user may select from Medication Codes by clicking  and selecting the appropriate medication.
  - Reason: Enter the reason the student is taking the medication or click  and select the appropriate reason.
  - Type of Medication: Select from the drop-down list if the medication is *Emergency*, *Over-the-Counter*, *Prescription* or *Scheduled*. (Scheduled must be selected in order for the medication to print on the *Medication Checklist Report*.
  - Administered By: Select from the drop-down list if the medication is *Supervised Self-Medication* or *Unsupervised Self-Medication*.
  - Expiration Date: If Emergency is selected as the "Type" the expiration date of that medication must be entered.
  - Dosage: Enter the dosage amount. For example, *2 tablets*.
  - Frequency: Enter the dosage frequency. For example, *2x/Day* for two times per day.

- Parent Written Authorization: Check this box if the student's parents have given written authorization for the student to receive medication.
- Parent Sign Date: Enter the date the authorization was received in this field.
- Physicians Written Request: Check this box if the student's physician issued a written statement requesting that the student receive medication. Enter the date the statement was received in the *Physician Written Request Date* field below.

- Click **OK** to save.

> Note: Once medication information has been saved, it is not editable. The only information that may be entered is "Omit" information. If a medication order is changed a new Medication entry needs to be completed.

Medication Times

- This tab, located in the bottom part of the menu, may be used for two different purposes. If the medication is to be administered on a *scheduled* basis, enter a regular time at which the medication is to be administered. If the medication is to be administered on an *emergency* basis, enter the specific time following the emergency at which it was administered.
- If more than one medication is listed in the Medication browse box, make sure the correct one is highlighted. Click **Insert** in the bottom right corner to add a Medication Time.
- Enter the *Administered Time*. Additional notes may be entered in the field provided.
- Click **OK** to save.

Medication Log

- This field may be used in conjunction with *Medication Times* to keep track of *scheduled* medications. The scheduled time would be entered under *Medication Times*. The actual date and time of each medication administration would be entered under *Medication Log*.
- If more than one medication is listed in the Medication browse box, make sure the correct one is highlighted. Click **Insert** below the Medication Log browse box to add a *Medication Time*.
- Enter the date and time at which the medication was administered.
- For *Examiner*, use the drop-down arrow to select the employee who administered the medication. Enter any notes in the field provided.
- Click **OK** to save.

Printing Medication Reports

Two printer icons are displayed in the Medication menu:

- Click the  icon to generate a report listing the following: Medication; Reason; Type of Medication (i.e., Scheduled or Emergency); and Start and End Date.
- Click the  icon to generate a detailed report of the above information as well as dosage details and physician, pharmacy and parent information.

Referrals

- Click the **Referrals** button to add a referral record for a student.
- Click **Insert** and enter the appropriate information in the fields provided. Most of the data fields are self-explanatory. Following are some possible exceptions:
  - Referral Type: Use the drop-down arrow to select a Referral Type. All Referral Types are entered in User Define Codes (Page 5) of the Code Maintenance Desktop menu under Utility Desktop. The type *Referral* is a preinstalled code. Additional codes may be added by the user.
  - Referral Date and Time: These fields will default to the current date and time. The user may change either of these fields by double-clicking on them.
  - Check *Parent Notification* if the student's parents have been notified of the referral action.
  - Attached to IEP: Check box if this referral will be attached to an IEP in STISets.
- Click **OK** to save.

Printing Referral Reports

- Click the  icon to print the referrals for the student.
- Information for all ten screening categories is entered here. The procedure for entering screening information is essentially the same as that for entering general medical information. Simply select the Screening, choose **Insert** or **Change** and entered the necessary information. Screenings may also be **Deleted** if necessary.

Screenings

- Screenings and Exams can be entered on the Add/Edit Screen, Screenings/Exams available include:

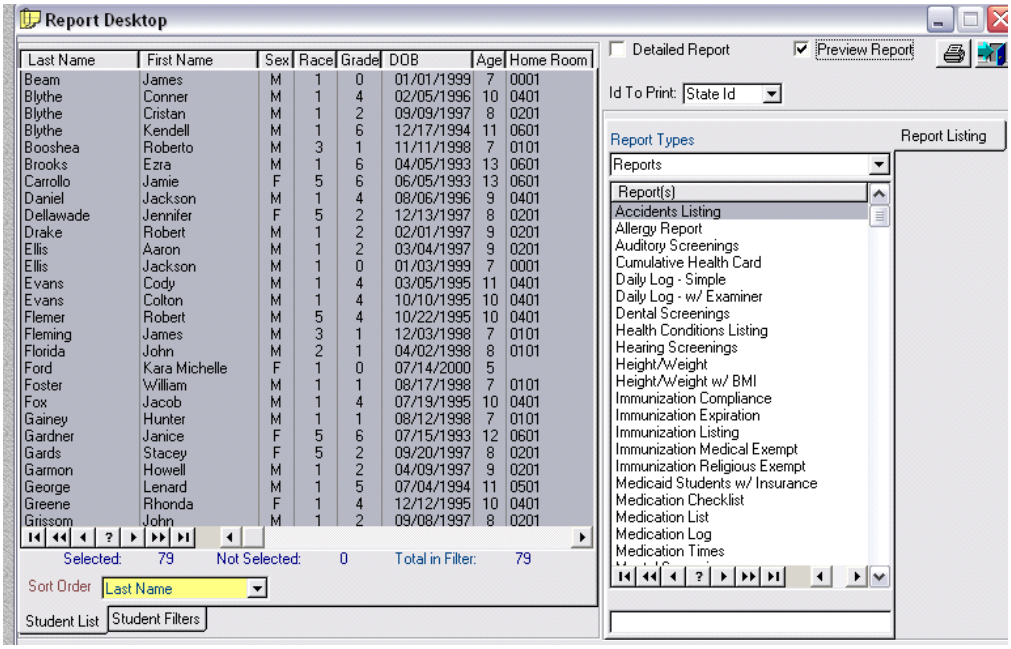
  (* Indicates Required for Kentucky State Reporting)
  - Auditory
  - Dental
  - Hearing*
  - Height/Weight
  - Mental
  - Physical *
  - Scoliosis *
  - Tuberculosis
  - Vision (Screening or Exam) *
  - User Defined (allows the user to enter any screenings not otherwise available.
- To enter/modify a Screening or Exam follow these procedures:
  - Select the button that represents the screening/exam being recorded.
  - Click **Insert** to create a new record or select a record and click **Change** to modify an existing record.
  - Populate the necessary fields for the record.
  - Click **OK**.
- To Delete a Screening or Exam:

- Select the button that represents the screening/exam that needs to be deleted.
- Select the record that needs to be deleted and click **Delete**.
- Verify that the correct record to be deleted has been selected and click **OK** when the warning message displays.

Note: When the Height and Weight information is entered under the Physical Exam screen, the information will create an entry in the Height/Weight screen.

Reports Desktop in STIHealth

Click the  icon to print or view summary reports for any phase of student health care.



Report types available include:

- Reports
- Labels
- Analytical
- Letters

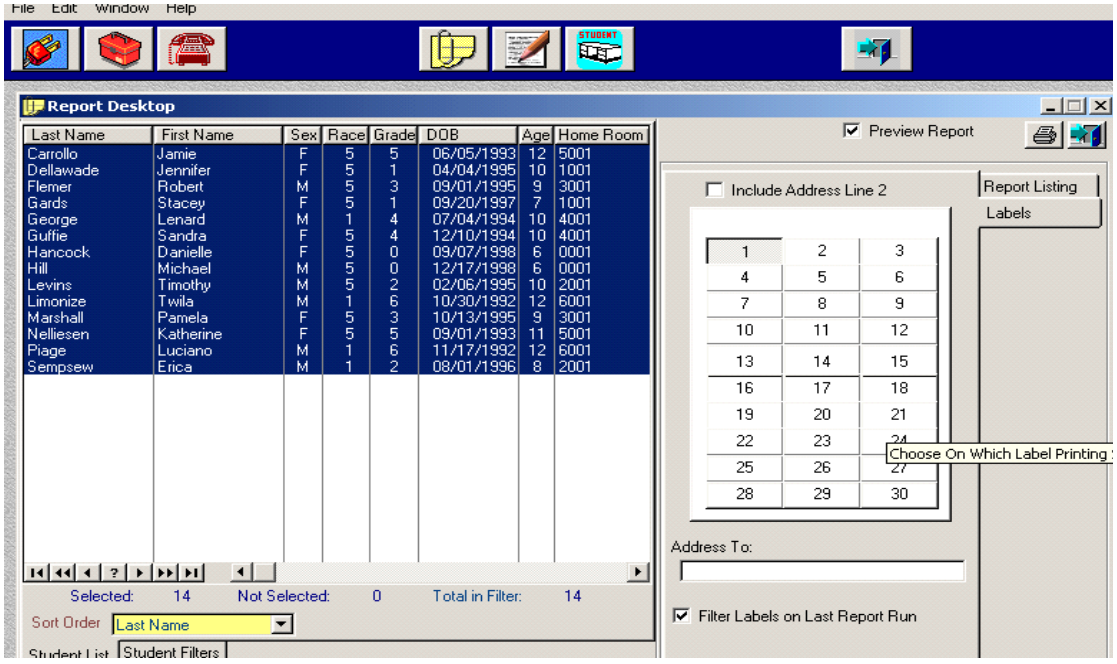
Actual reports include:
(* Indicates a Detailed Report is available)
(^ Indicates a Reverse Listing is available)

- Accidents Listing *
- Allergy Report *
- Auditory Screening *^
- Cumulative Health Card
- Daily Log Simple
- Daily Log w/examiner *
- Dental Screenings ^
- Health Conditions Listing
- Hearing Screening * ^
- Height/Weight *
- Height/Weight with BMI
- Immunization Compliance *
- Immunization Expiration
- Immunization Listing
- Immunization Medical Exempt
- Immunization Religious Exempt
- Medicaid Students w/Insurance
- Medication Checklist
- Medication List
- Medication Log
- Medication Times
- Mental Screenings
- Missing Expiration Date
- Physical Exam * ^
- Provisional Certificate
- Referral Screenings
- Scoliosis Screenings *^
- Students with Medical Alerts
- Students w/Insurance
- Students w/School Insurance
- Students w/o School Insurance
- Tuberculosis Screening *
- User Define Screenings *
- Vision Screenings * ^

Labels include:

- Avery 5160
- Avery 5161
- Avery 5366 (Student Folder Labels)
- Immunization Labels

> Note: An option located on the labels tab will allow the user to filter the labels from previous report selected. There is also an option to select which label to begin printing.



Analytical Reports include:

- Hearing Screening Monthly Tally
- Medical Condition Totals
- Outcome Tallies by Day
- Outcome Tallies by Month
- Physical Screening Monthly Tally
- Scoliosis Screening Monthly Tally
- Symptom Tallies by Day
- Symptom Tallies by Month
- Treatment Tallies by Day
- Treatment Tallies by Month
- Vision Screening Monthly Tally

Letters include:

- Compliance
- Dental
- Hearing
- Immunizations
- Physicals
- Scoliosis
- Student
- Vision

> Note: In order to use the Letters feature, the **Letter System File** must first be set up under **Utilities Desktop**. Also, the user must set up letters using merge fields in Microsoft Word.

Selecting Students for Reports

To generate reports for students, the user has the option to **Select** and **Deselect** single students under the *Student List* tab by simply clicking on the students' record. The user may also right click on the student listing and choose to **Select All** or **Reverse** the current selection.

The second option is to click the *Student Filters* tab. The user may then filter students by *Race/Ethnic Group*, *Homeroom*, *Age*, *Grade* and *Gender*. From this screen, the user also has the option to include withdrawn and inactive students.

Generating Reports

Once the desired students have been selected, the user has several different report options. The options described below do not necessarily apply to each report.

- **Preview Report**: This box is located at the upper right section of the screen. Check the box to generate an onscreen report preview prior to printing the hard copy. Uncheck the box to print a hard copy immediately, with no preview.
- **Detailed Report**: Certain reports also have a check box available for the user to generate a Detailed Report. To generate a Simple Report, uncheck the box.
- **Report Listing**: This tab will display all of the reports available and will allow the user to select which report to generate.
- **Dates**: Allows the user to select a date range. Leave blank to include all dates.
- **Results**: Only available for the reports containing results information, this tab will allow the user to select the results that they wish to show on the report.
- **Screening Type**: Only available on screening reports, this tab will allow the user to select to include or exclude Screening Type codes.
- **Symptom**: Allows the user to select the symptoms to include on the report.
- **Treatment**: Allows the user to select the treatments to include on the report.
- **Outcome**: Allows the user to select the outcomes to include on the report.
- **Reverse Option**: This feature allows the user to select to show students who do not have records for the report listing selected. In order to generate a report showing students with missing information the user must select the

checkbox to the left of *List Students With No Records in Selected Filter Range*. Once this option has been selected, the user must un-select the box to generate students with records.

The following tabs are report specific and appear only with the applicable report:

- **Allergy Report – Allergies**: Displays a listing of all of the Allergies listed in the Code Desktop. The user may choose to select as few or as many allergies as desired for the report.
- **Health Conditions Listing - Med. Conditions**: Displays a listing of all of the Medical Conditions listed in the Codes Desktop.
- **Immunization Expiration – Immun.**: Allows the user to select to Include Medical Exempt Students, Include Religious Exempt Students, and chose All, Standard or Provisional Certificate Types.
- **Immunization Listing – Shots**: Allows the user to select which of the shot codes will appear on the report.
- **Missing Expiration Date - Immun**.: Allows the user to select to Include Medical Exempt Students, Include Religious Exempt Students, and chose All, Standard or Provisional Certificate Types.
- **Immunization Compliance - Shots**: Allows the user to select which of the shot codes will appear on the report.
- **Vision Screening -Vision**: Allows the user to filter students Tested Wearing Corrective Lenses, students with Vision Problems, and students who have a vision Referral.

Generating Letters

Letters may be generated addressing the following issues: *Compliance*, *Dental*, *Hearing*, *Immunizations*, *Physicals*, *Scoliosis*, *Student* and *Vision*.

Note: This feature is only available to users who have Microsoft Word® installed on their workstation.

Select students just as if creating a report. Once the desired students have been selected, the user has several different letter options, described below. All options do not apply to each type of letter.

- **Dates:** Allows the user to select a date range. Leave blank to include all dates.
- **Shots:** Allows the user to select the shot action desired.
- **Letters:** Allows the user to select the type of letter needed.
- **Reverse Option:** This feature allows the user to select students who do not have records for the report listing selected. In order to generate a report showing students with missing information, the user must select the checkbox to the left of *List Students With No Records in Selected Filter Range*. Once this option has been selected, the user must de-select the box to generate students with records.
- **Screening Types:** This tab will allow the user to select to include or exclude Screening Type codes.
- **Results:** This tab allows the user to select the results to include in the letter.
- **Immunization:** This tab allows the user to select to Include Medical Exempt Students, Include Religious Exempt Students; choose All, Standard, or Provisional Certificate Types*;* Dates to Filter by Expiration, Exclusion, or Provisional Admit Date: and Information Source.
- **Re-Screening:** This tab allows the user to select whether the student needs a re-screening.
- **Vision:** The tab allows the user to select whether corrective lens were used, a vision problem was detected, and a referral is indicated.

To complete a letter, perform the following steps:

- Select the students for whom the letters are to be created. .
- Select **Letters** as the *Report Type*.

- Chose the report to run (*Compliance, Dental, Hearing, Immunizations, Physicals, Scoliosis, Student, or Vision).*
- Chose the information to include from the tabs at right (i.e., *Dates*, *Screening Type* and *Reverse Option*).
- Once selections have been made, click the *Letters* tab on the right.
- If no letters are saved, or the necessary letter has not been saved, the user will have to click the  icon.
- To insert a new letter, click **Insert**.
- Enter the *Code* and the *Description* that are to be associated with the letter.
- Click the **Letter** button.
- Microsoft Word® will open.
- The user will use a combination of *merge fields* and text to create the letter.
- The user can draft the document to include any text or merge fields desired.
- The format (bold, font size, etc.) of the document is editable just as in any other Word application.
- **The letter MUST contain at least one merge field for this feature to work properly.** (There is no maximum limit on how many merge fields can be used).
- After setting up the document as desired, save the document.
- The document is now available to use for letters with STIHealth.

There is also a Copy feature available in Letters:

- If the user wishes to make an exact copy of an existing letter (including both text and merge fields) the user will select Add/Edit Letters, then select the letter to copy and press the copy button.
- The user will be instructed to change the Letter code (the default is ZZZZ)
- After the letter has been copied, the user will select the new letter, change the code and can press the Letter button to go to the letter in Microsoft Word to make any changes.

Appendix A

Release Notes for STIHealth Update (Version 9.0)

FINAL RELEASE WILL BE June 2006.

****THIS IS A MANDATORY UPDATE****

FOR YOUR INFORMATION

The next update for STIHealth is not scheduled. Please watch our website for details of the next update, all list server members will be notified when the next version is released.

If STIHealth is being run at the local school, that school will need Version 9.0 of STIOffice in order for the STIHealth 9.0 Updates to run properly. Please coordinate with the proper STIOffice contact at your local school if there any questions.

Special Notice!!!

!!!! The user MUST run this utility after updating to version 9.0!!!

Go to Utility Desktop > Utility Window > press the button labeled "Move Alert Messages". This will move the alert messages from the "Medical" button to the "Allergy/Alerts" button AND add new codes to the appropriate code banks. The alerts messages will be moved to Health Conditions Description textbox with "Other" in the drop down box to the left. The alert checkbox will be auto-selected when the alert message(s) are moved to the screen.

ADD/EDIT

201 - Add/Edit | Allergy/Alerts | Added a new button named 'Allergy/Alerts' that includes Unusual Health Problems (with alert and emergency meds), Allergy (with alert and Epi Pen) data entry fields.

201 - Medical | Unusual Health Problems have been moved from Medical to 'Allergy/Alerts' button.

283 – Allergy/Alerts | Allergy | added a checkbox labeled "Alert". If this checkbox is selected on any allergy, it will show in Office, District and Classroom.

359 - Allergy/Alerts | Allergy | added a checkbox labeled "Epi-pen".

284 – Allergy/Alerts | Unusual Health Problems | Added an "Alert" checkbox to the left of each drop down. If this checkbox is selected, it will show the "Unusual Health Problem" text and description in Office, District and Classroom. For example: If ADHD is selected and the Alert checkbox is checked, ADHD will appear in Office, District and Classroom Alert fields.

285 - Allergy/Alerts | Unusual Health Problems | A textbox has been added to the right of each Unusual Health Problem drop down that will allow the user to give a description of any Unusual Health.

363 - Allergy/Alerts | Unusual Health Problems | Added a checkbox to the left of each Unusual Health Problem labeled "Emergency Med". If this checkbox is selected, it will show in Office, District and Classroom.

110 – Immunization Screen – Field added to display student's grade.

113 – Immunization Screen – "Certificate Type" is now a required field. The user must select either "Standard" or "Provisional" before saving the record. If no type is selected, the user will receive a prompt saying, "Certificate Type must be selected".

288 – Medication | filters added to the browse window that will allow the user to filter "Emergency Meds Only".

288 - Medication | Added Expiration Date to browse view.

290 - Medication | Added Expiration Date field to data entry screen. It will be activated when type of medication is set to Emergency.

116 – Hearing Screening | Results – added "Refused" as a results option.

200 – Physical Screening | The second column of the report that can be printed from the browse window now reads 'Exam Date' instead of 'Screening Date'.

115 – Vision Screening | Results – added "Refused" as a results option.

376 – Batch Entry | inactive and withdrawn students do not appear in the Add/Edit desktop queue by default. If an inactive or withdrawn student needs to be included in a batch entry, the user will need to select the appropriate filter before selecting Batch Entry.

205 – Student Health Profile | General Medical . If no data has been entered on the medical screen, there will be no General Medical record on the Student Health Profile.

Student Health Profile | General Medical | If no Health Insurance Company data has been entered on the medical screen, the statement, 'no data entered' will appear on the screen.

Student Health Profile | Added Allergy/Alerts Tab that will allow the user to view all information entered for Allergy and Unusual Health Problems. This tab also includes a quick view of Alerts, Epi-Pen/Emergency Meds that have been indicated on the Allergy and Unusual Health Problem data entry screens.

203 - STIOffice button | Added Contact information, Attendance Information (press F4) and Discipline information.

REPORTS DESKTOP

366 - Reports Desktop | Defaulted ALL reports to include 'Active' students only.

199 – Reports Desktop | ALL reports | added filter named "ID to print"– this filter will include State ID (SSID), Student Number, Social Security Number (SSN) and NONE. The ID selected in this drop down will print on the left side of the student's name. If the user selects State ID and there is no State ID for a student, the report field will be blank for that student.

364 - Reports Desktop | All reports will include School Name, Number and Date Run.

Reports Desktop | Allergy Report | added Epi Pen and Alert indicators for each allergy listed on the report.

Reports Desktop | Health Conditions Listings | added Alert, Emergency Med and Description field for each Unusual Health Problem listed on the report.

365 - Reports Desktop | Missing Expiration Date and Immunization Expiration Reports | filters defaulted to include Medical Exempt students.

365 - Reports Desktop | Missing Expiration Date and Immunization Expiration Reports | Medical Exempt students will be indicated with an ‘ * ‘.

368 - Reports Desktop | Scoliosis Screenings report | added “Reverse Option” to the filter.

368 - Reports Desktop | Auditory Screenings report | added “Reverse Option” to the filter.

369 – Reports Desktop | Medication Times | added Start Date and End Date.

369 – Reports Desktop | Medication Times | Type will print description instead of code.

369 – Reports Desktop | Medication Log | added Start Date and End Date.

369 – Reports Desktop | Medication Log | Type will print description instead of code.

370 - Reports Desktop | Shot Compliance renamed to “Immunization Compliance”

370 - Reports Desktop | Immunization Compliance report heading reads Immunization Compliance Report.

372 – Reports Desktop | Immunization Compliance | Detailed Report | Changed heading 'Good Shots' to 'Shot Dates'

372 – Reports Desktop | Immunization Compliance | Detailed Report | now includes all shot dates.

372 – Reports Desktop | Immunization Compliance | Detailed Report | Shots that are out of date range are in bold on a line below the shots that are in range.

372 – Reports Desktop | Immunization Compliance | Detailed Report | Shot Type with No Record are in bold font.

372 – Reports Desktop | Immunization Compliance | Detailed Report | Added 'Certificate Type' to the report.

372 – Reports Desktop | Immunization Compliance | Detailed Report | An asterisk ‘*‘ will indicate any student who are marked Medical and double asterisks ‘**‘ will indicate any student who are marked Religious Exempt.

372 – Reports Desktop | Immunization Compliance | Detailed Report | Added Medical Exempt Notes field.

406 – Reports Desktop | Immunization Compliance | Hib compliance rules adjusted.

UTILITY DESKTOP

258 – Utility Desktop | Code Desktop | Health Issues | Added codes:
780.39 Seizures
999.9 Other

293 – Utility Desktop | Code Desktop | Allergy and Immunization Type | Added F-17 Fish/Shellfish/Seafood (specify) to the code bank.

362 – Utility Desktop | Delete Health Records | Added ability to Lookup by Last Name, Student ID, State ID, Homeroom and Grade Level.

362 – Utility Desktop | Delete Health Records | Added ability to sort by Grade Level.

116 – Hearing Screening | Results – added “Refused” as a results option.

115 – Vision Screening | Results – added “Refused” as a results option.

378 - Schools/Locations | “Our School” is checked on by default when a new school/location is “Inserted”.

Uh.exe
This executable has been removed for version 9.0.

Appendix B

Release Notes for STIDistrict Health Update (Version 9.0.0)

FFINAL RELEASE WILL BE JUNE 2006

FOR YOUR INFORMATION

Next Update is not scheduled. Please watch our website for details of the next update, all list server members will be notified when the next version is released.

STUDENT DESKTOP

The Student Desktop now has 5 sort options along with a search feature for each. The sort options are Student Name, Student Number, School, Grade, and Homeroom.

The Medical alert icon will appear on the Student Desktop if applicable.

Forms

Allergies/Alerts
Changed the Allergy button to 'Allergies/Alerts' that includes Health Conditions and Allergy data entry fields.

Allergies/Alerts |
Added "Alert" and "Epi-pen" fields to browse view.

Allergies/Alerts | Allergy
Added "Alert" and "Epi-pen" checkboxes to form.

Allergies/Alerts | Unusual Health Problems
Added browse that displays Unusual Health problems, if the problem is an alert, if the problem has emergency medication, and the notes of any Unusual Health Problem containing the word "Other".

Medical
Unusual Health Problems have been moved from Medical to 'Allergies/Alerts' button.

Medication
Added Expiration to browse view.

Medication
Added Expiration to form.

Physical Screening
Changed the field description from 'Screening Date' to 'Exam Date'.

Student Profile
This window was added.

REPORT DESKTOP

Reports
ALL reports have been defaulted to include 'Active' students only.

Added report option of "ID to print"– this will include Alternate ID, Social Security, State ID, Student ID, and None. The ID selected is the ID that will print on the report. If the user selects an ID and there is no ID for a student, the report field will be blank.

All reports will include School Name, Number and Date Run.

Tallies were added for the following reports: Health Conditions, Hearing Screenings, Physical Screenings, Scoliosis Screenings, and Vision Screenings.

Health Condition Report
This report prints health condition totals by school and district. A text file is also generated by the name "Health_Condition.txt". If a "Health_Condition.txt" file already exists, it is overwritten.

Immunization Compliance
Physical 1 and Physical 2 compliance are considered for whether a student is compliant or non-compliant.

Medication Times
Added Start Date and End Date. Type will print description instead of code.

Medication Log
Added Start Date and End Date. Type will print description instead of code.

Student Health Report
This report prints immunization compliance, type, and shot totals; vision exam and screening information; hearing, physical, and scoliosis screening information. A text file is also generated by the name "Student_Health_Report.txt". If a "Student_Health_Report.txt" file already exists, it is overwritten.

Varicella Listing
This report has the option to either print a list of students who have had the disease or not had the disease.

Without Expire Date, Expired Immunization Reports
These reports were defaulted to include Medical Exempt students. Medical Exempt students will be indicated with an ' * '.

Appendix C

Immunization Shot Compliance Report Guide

The STI Health Immunization Shot Compliance Guide was developed to assist schools in determining if students were compliant with meeting the immunization requirements as described in 902 KAR 2: 060 Immunization Schedule. These immunization rules were loaded into the computer program, therefore the computer program will identify if shots are: missing; given at appropriate time intervals; given at inappropriate time intervals and when the next shot is due.

How each shot type matches the Immunization Schedule criteria listed in 902 KAR 2:060 is then labeled by the codes listed below. If you have a shot type showing non-compliance for no obvious reason, please check the dates the shot was given and the regulation interval times required as stated in the Immunization Schedule. The time interval between shots have to meet the time interval criteria stated in the regulation to be a valid shot.

Step I: Keys to Interpreting Codes for each designated shot type:

(C)- compliance-has met shot requirements in 902 KAR 2:060 Immunization Schedule

(N)- non-compliance- at least one shot type does not meet 902 KAR 2:060 criteria. You should check the data entry and student certificate to make sure the data was entered correctly or that the shot was given at the required time intervals.

(E)-Exempt – could be one of the following: Religious, Medical, or not required as age appropriate according to the Immunization Schedule 902 KAR 2:060

(X)- No shot records – no certificate in student's file, or no data entered in computer

Step II: Interpreting the Shot Type

DTaP Column

THERE IS NO SEPARATE COLUMN FOR THE TD BOOSTER. Therefore, DTaP and TD Booster are both reported in this column.

Please Note: Per Shirley Herald, Nurse Consultant for Kentucky Immunization Program: Tetanus toxoid is acceptable for the TD Booster.

- If (C) is present in this column, then the student is compliant with the shots required by the regulation as age appropriate.
- If (N) is present in this column, then the student is out of compliance with either the DTaP or the TD Booster (check records to determine if data entry error or child has not received shot)
- If (E) is present in this column, then all shots for student have been completed according to age appropriate requirements. (**Example**: If child has received all DTaP shots but not age appropriate for TD booster, E will appear in the column. The child is exempt (E) for the DTaP and not yet age appropriate to receive TD booster)

- If (X) is present in this column, no shot records (check records to determine if data entry error or child has not received shot)

Polio Column

- If (C) is present in this column, then the shot series is compliant with the regulation requirements as age appropriate
- If (N) is present in this column, then the student is out of compliance (see Keys to Interpreting Codes)
- If (E) is present in this column, then the student is exempt for this shot type (see Keys to Interpreting Codes)
- If (X) is present in this column, no shot records (check records to determine if data entry error or child has not received shot)

MMR Column

- If (C) is present in this column, then the shot series is compliant with the regulation requirements as age appropriate
- If (N) is present in this column, then the student is out of compliance. (Compare number of days between MMR # 1 and 2. MMR's require a minimum ***24 days*** interval between shots) **– Note**- if Varicella and MMR given at the same time, must have ***28 day*** interval between the next live vaccines)
- If (E) is present in this column, then the student is exempt for this shot type (see Keys to Interpreting Codes)
- If (X) is present in this column, no shot records (check records to determine if data entry error or child has not received)

Hib Column

- If (C) is present in this column, then the shot series is compliant with the regulation requirements as age appropriate
- If (N) is present in this column, then the student is out of compliance (see Keys to Codes)
- If (E) is present in this column, then the student is exempt for this shot type
- **(REMINDER**: Once child is five years of age, shot not required)
- If (X) is present in this column, no shot records for age appropriate (check records to determine if data entry error or child has not received)

Hep Bp Column

According to 902 KAR 2:060 Immunization Schedules, for sixth grade entry, not withstanding age, if a child born October 1, 1992 or later, shall have received one of the following:

1. Hep Bp - Pediatric Dose-three doses required **OR**
2. Hep Ba - Adult Dose-two doses required for student aged 11-15 and completed by age 16
    - If (C) is present in this column, then the shot series is compliant with the regulation requirements as age appropriate
    - If (N) is present in this column, then the student is out of compliance (see Keys to Codes)
    - If (E) is present in this column, then the student is exempt for this shot type (see Keys to Interpreting Codes)
    - If (X) is present in this column, no shot records (check records to determine if data entry error or child has not received)

Varicella (VAR) Column

- If (C) is present in this column, then the shot series is compliant with the regulation requirements as age appropriate
- If (N) is present in this column, then the student is out of compliance.(Note: If given with MMR, need 28 days between live vaccines.)
- If (E) is present in this column, then the student is exempt for this shot type (see Keys to Interpreting Codes)
- If (X) is present in this column, no shot records (check records to determine if data entry error or child has not received)

If student has 'had disease' the report will show (C) Compliant

Physical Column

Phys 1- initial exam (1 year prior to entering a Kentucky public school-5th grade, be sure to verify the grade when entering data that the correct grade has been selected.)

- If (C) is present then student is in compliance with regulation
- If (N) is present in this column, then the student is out of compliance (check records to determine if data entry error or child has not received)
- If (E) is present in this column, then the student is exempt
- If (X) is present then no record of physical (check records to determine if data entry error or child has not received)

Phys2- 6th grade exam (may be given one year prior to entry to 6th grade)

- If (C) is present then student is in compliance with regulation
- If (N) is present in this column, then the student is out of compliance (check records to determine if data entry error or child has not received)
- If (E) is present in this column, then the student is exempt
- If (X) is present then no record of physical (check records to determine if data entry error or child has not received)

Certificate Expiration Columns (AMMENDED 1/25/06)

Recorded Column- expiration date written by the healthcare provider's office at the bottom of the immunization certificate. The date written on the certificate is when the next shot is due. (**NOTE**: For the Provisional Certificate, there is a two-week window of opportunity in which the shot may be given before the certificate is not longer valid.)
Calculated:

Low- earliest expiration date that next shot would be due based upon regulation

High- latest expiration date that next shot would be due based upon regulation

If the student does not receive the next required shot by the time of the recorded (written) expiration date on the Immunization Certificate, the certificate is expired and will show up as non-compliant in the Certificate Status column. (The Calculated dates in the low and high range are merely a "FYI" of when the shot may be given.)

Certificate Status

If (C) present then certificate expiration date is in compliance (recorded date falls between low and high-calculated range)

If (N) present then certificate expiration date is out of compliance (recorded date does not fall between low and high calculated range) OR the shot was not given by the date written as the expiration date on the Immunization Certificate.

Example : The date range for the next shot due is : 9/30/04 (low range) and 12/30/09 (high).

HOWEVER, The Certificate has a recorded (written) expiration date of 12/30/05. Today is 1/25/06. The certificate is now expired and shows Non-complaint on the Shot Compliance Report. This is correct- 1/25/06 is after the recorded (written) expiration date of 12/30/05. Therefore, since the certificate is expired, the student certificate's status is Non-compliant.

No (E) will be recorded because expiration date is required by regulations

If (X) is present no record available (check records to determine if data entry error or child has not received)

Appendix D

KDE Contacts

Data Policy Management and Research
(502) 564-5279
Windy Newton……Windy.Newton@education.ky.gov
Michele Kays ……Michele.Kays@education.ky.gov
Troy McGinnis……Troy.McGinnis@education.ky.gov

Attendance
(502) 564-3846
Sherri Clusky……Sherri.Clusky@education.ky.gov
Tracy Browning……Tracy.Browning@education.ky.gov

Calendar
(502) 564-3846
Sherri Clusky……Sherri.Clusky@education.ky.gov
Michael Speer……Michael.Speer@education.ky.gov

Extended School Services
(502) 564-4772
Jennifer Carroll……Jennifer.Carroll@education.ky.gov
Monica Simpson……Monica.Simpson@education.ky.gov

Federal Programs – Title 1
(502) 564-3791
Diane Robertson……Diane.Robertson@education.ky.gov

FRYSC
(502) 564-4986
Michael Denney……Michael.Denney@ky.gov

Gifted and Talented
(502) 564-2106
Leah Ellis……Leah.Ellis@education.ky.gov
Greg Finkbonner……Greg.Finkbonner@education.ky.gov

Growth Factor
(502) 564-3846
Karen Wirth……Karen.Wirth@education.ky.gov

Health Services
(502) 564-2706
Karen Erwin……Karen.Erwin@education.ky.gov

Homeless Children/Youth
(502) 564-3791
Mary Marshall……Mary.Marshall@education.ky.gov

KEES
(800) 928-8926
Rebecca Gilpatrick……RGILPATRICK@kheaa.com

LEAD
Education Professional Standards Board
(502) 564-4606
Cindy Godsey……Cindy.Godsey@ky.gov

Learn and Serve
(502) 564-4201
Joan Howard……Joan.Howard@education.ky.gov

Language Proficiency
(502) 564-2106
Shelda Hale……Shelda.Hale@education.ky.gov
Maureen Keithley……Maureen.Keithley@education.ky.gov
Edgar Adams……Edgar.Adams@education.ky.gov

Preschool
(502) 564-7056
Annie Rooney French……Annie.French@education.ky.gov

Non-Academic
(502) 564-5279
Chris Thacker……Chris.Thacker@education.ky.gov

SAAR
(502) 564-3846
Karen Wirth……Karen.Wirth@education.ky.gov

Safe Schools
(502) 564-3678
Libby Taylor……Libby.Taylor@education.ky.gov
Nijel Clayton……Nijel.Clayton@education.ky.gov

Secondary GED
(502) 564-4772
Jennifer Carroll……Jennifer.Carroll@education.ky.gov

Special Education Services
(502) 564-5279
Chris Thacker……Chris.Thacker@education.ky.gov

Standardized Course Codes
(502) 564-9850
Robin Chandler……Robin.Chandler@education.ky.gov

TEDS
(502) 564-3472
Kimberly Rice……Kimberly.Rice@education.ky.gov

Index

2

2006-07 End of Year Reporting 2

A

Accident Report 26
Add/Edit Student Information Desktop 23
Allergies/Alerts 18
Allergy Data Entry 12
Allergy/Alert 11, 13
Appendix A 40
Appendix B 44
Appendix C 46
Appendix D 50

B

Batch Entry 24

C

Changes and Updates 13

D

Daily Log 27
District Health Changes and Updates 17

G

Generating Letters 38
Generating Reports 37

H

Hearing Screening Information 9

I

Immunization 28
Immunization Shot Compliance Report Guide 46
Immunizations 4

K

KDE Contacts 50

M

Medical 26
Medication 14, 19, 31
Medication and Reason 14
Move Alert Messages 1
Multiple Data Path Setup 22

P

Physical Exam Information 6
Purpose 2

R

Referrals 33
Release Notes for STIDistrict Health Update (Version 9.0.0) 44
Release Notes for STIHealth Update (Version 9.0) 40
Report Desktop 20
Reports 16
Reports Desktop in STIHealth 34

S

Scoliosis Screening Information 10
Screenings 33
Selecting Students for Reports 37
Start of Year Procedures 1
Step I
  Keys to Interpreting Codes for each designated shot type: 46
Step II
  Interpreting the Shot Type 46
STIHealth 9.0 DATA STANDARDS - 2006-07 2
STIOffice View Window 16
Student Desktop 17
Student Health Profile 16
Student Profile 20

V

Vision Exam Information 7
Vision Screening Information 8